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# THE JOURNAL

— OF THE —

# Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV  
No. 1

St. Augustine and Jacksonville, Fla., July, 1917

Yearly Subscription, \$1.00  
Single Copy, 15c

1917-18

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, July, 1917

Number 1

## ORIGINAL ARTICLES

### PRESENCE OF TUBERCLE BACILLI IN SPECIMENS OF FECES EX- AMINED FOR ANIMAL PARASITES.\*

*A Preliminary Report.*

HAROLD H. FOX, M. D.,

Tallahassee, Fla.

Uncinariasis in the human race because of its local and general manifestations is widely recognized as a probable important factor in the regions in which it prevails in rendering the human system susceptible to the invasion of the tubercle bacillus.

In view of this fact surprisingly little laboratory work has been done to determine the value of routine examinations to detect the presence of tubercle bacilli in the feces, and so far as I can ascertain no examinations have been reported showing whether the tubercle bacilli are more commonly found in the feces of patients suffering from hookworm disease than in the stools of supposedly normal individuals. Perhaps this is due to the belief that acid-fast bacilli are commonly found in the feces of normal individuals.

It is true that various acid-fast spores and oval bodies including the clostridium butyricum are frequently found, but they differ so widely in appearance from the tubercle bacillus that any trained observer should be able to differentiate them.

It has been thought that the smegma bacillus was so closely related to the tubercle bacillus, both as concerned its staining properties and its morphology and that it was so commonly found in the feces, that positive

reports based on examinations of stained specimens only, without cultural or inoculation tests, were of little value. Laird, Kite and Stewart<sup>1</sup> working in the laboratory of the Adirondacks Cottage Sanatorium, found that of 101 patients having positive sputa 72 per cent showed acid-fast bacilli in the feces, and that acid-fast bacilli were not found in 96 per cent of 54 cases having negative sputa. They also found, by animal inoculation with feces containing acid-fast bacilli, that in "62 instances in which the animal lived long enough for tuberculosis to develop, at autopsy it showed positive macroscopic lesions in 77 per cent of the cases, and that in 34 inoculation experiments in which the feces did not contain acid-fast bacilli, 95 per cent of the guinea pigs did not show positive lesions, and in the one case which did develop tubercular lesions, they are unable to state positively regarding the possibility of an error in their records, or in the condition of the guinea pig examined."

Rittle-Wilenko<sup>2</sup> found, at autopsy, tubercular ulcers in the intestines of 29 cases in which acid-fast bacilli had been found in the stools.

Alexander<sup>3</sup> failed to find acid-fast bacilli in the feces of 129 non-tubercular cases.

Phillips and Porter<sup>4</sup> found acid-fast bacilli in the stools of 75 out of 100 tubercular patients examined, and failed to find acid-fast bacilli in the stools of 9 supposedly normal persons.

Wilson and Rosenberger<sup>5</sup> found tubercle bacilli in the stools of 100 patients showing tubercle bacilli in the sputa, and in 21 per cent of 1,033 specimens which did not show tubercle bacilli in the sputa.

\*Read by title before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.



Bergstrand<sup>6</sup> found that in the stools of 60 non-tubercular persons, tubercle bacilli were not found at any time, and that in 110 adults examined, having positive sputa, 90 per cent showed acid-fast bacilli in the feces.

Keller and Moravek<sup>7</sup> report as a result of their investigations that under normal conditions there are no acid-fast bacilli in the feces, and that acid-fast bacilli found in the feces, resisting the decolorization with 25 per cent nitric acid, water solution, followed by 80 per cent alcohol, are tubercle bacilli and no other.

These reports would seem to prove that acid-fast bacilli found in the feces are practically always tubercle bacilli.

In order to determine the frequency with which tubercle bacilli are found in the stools, and in order to determine whether they are more frequently found in feces containing hookworm ova or in feces negative for this intestinal parasite, a study was made of 50 unselected specimens of feces of different patients submitted to the laboratory for examination for animal parasites:

27 were negative.

23 were positive for hookworm ova.

In order to prevent the possibility of introducing acid-fast organisms from previously used containers, only new containers were supplied to the physicians, and at the time of examination, in order to prevent the possibility of introducing acid-fast bacilli, such as had been reported to have been found in distilled water<sup>8</sup>, new glass slides were used, and from the distilled water used in diluting the specimens on the slides, 25 control slides were stained. These were all negative for tubercle bacilli.

*Technique of Examination:* Following the completion of the examination for animal parasites, a small amount of the fecal contents in the containers was transferred to a glass slide by means of a sterile platinum loop. This was then thoroughly rubbed up with a few drops of distilled water. Laird, Kite and Stewart had found this simple method to be equally as good and in some

instances, more reliable than the more elaborate antiformin method. A smear about the size of a copper penny was made. This was permitted to dry in air and was then fixed by passing the slide, smeared surface up, through the flame of a Bunsen burner.

Ziehl's carbol-fuchsin staining solution which had been previously tested with a known tubercular sputum was used. The 24-hour cold method was employed. The specimen was then washed in distilled water. Decolorization was performed by the use of 4 per cent concentrated hydrochloric acid, in 95 per cent alcohol, and was carried to the point where the smear failed to show any macroscopic trace of the carbol-fuchsin stain. With the idea in mind that the smegma bacillus was more readily decolorized than the tubercle bacillus, as an additional measure, the slides were then washed in 95 per cent alcohol, and then in distilled water. Stitt, of the Navy Medical School, states that this staining method will eliminate the smegma and similar bacilli<sup>9</sup>. Counterstaining was done for three minutes with freshly-prepared Loeffler's alkaline methylene blue. Smears were then washed with distilled water and dried in air without blotting.

For microscopic examination the oil immersion lens was used. Illumination was by means of a Spencer Lens Company lamp furnished with a day-lite glass.

No case was considered positive unless at least two distinct bacilli were found having the shape and acid-fast staining characteristics of the tubercle bacillus.

Before a smear was considered negative at least 300 oil immersion fields were examined.

In order to prevent prejudiced judgment playing a part in the examination, the smears were known to me by numbers only, and the results of the examination were marked plus or minus following the numbers. After all the slides had been gone over, the numbers were checked up with the daily records to determine whether or

not the case had been positive for hookworm.

The results were as follows:

In the 27 cases negative for hookworm ova, one case was positive for tubercle bacilli.

In the 23 cases positive for hookworm ova, five cases showed the bacillus of tuberculosis.

In other words, 12 per cent of the total number of specimens examined showed acid-fast bacilli, probably tubercle bacilli.

Of the cases negative for hookworm ova 3.7 per cent were positive for acid-fast bacilli.

Of the cases positive for hookworm ova 21.3 per cent were positive for acid-fast bacilli.

### *Summary.*

This report must of necessity be considered preliminary, for further tests, both by cultures and by animal inoculation, must be performed before it can be stated positively that the acid-fast bacilli found were tubercle bacilli. However, the reports of other workers referred to in this paper, show that acid-fast bacilli found in the stools, providing decolorization has been thoroughly performed, are undoubtedly tubercle bacilli.

If further laboratory work establishes the identity of the acid-fast organisms, which I found in the stools of hookworm cases, as being that of tubercle bacilli, and providing further work with a much larger number of specimens shows my report to be approximately correct, routine examinations should be made of all specimens of feces submitted to a Public Health laboratory, both on account of its ease of performance for the diagnosis of suspected tuberculosis in adults where the sputum is not obtainable, and because it furnishes a prolific field for study, important from a public health standpoint, in the investigation of uncinariasis.

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<sup>6</sup>Bergstrand: "Tubercle Bacilli in the Feces and Their Diagnostic Import." Abstract in the *Journal of the A. M. A.*, Vol. LXIV, No. 15, April 10, 1915, p. 1282. From *Hygeia*, Vol. LXXVII, No. 3, pp. 97-159.

<sup>7</sup>Keller and Noravek: "Significance of Presence of Acid-fast Bacilli in Feces of Patients Suffering from Joint Disease." *The Medical Record*. Vol. LXXXVIII, No. 21, November 20, 1915.

<sup>8</sup>Brem: "Investigation of Blood for Tubercle Bacilli." *Journal of the A. M. A.*, 1909, Vol. LIII, p. 72.

<sup>9</sup>E. R. Stitt: "Practical Bacteriology, Blood-work and Animal Parasitology." Second Edition, p. 75.

## THE RESPONSIBILITY OF THE GENERAL PRACTITIONER TO THE MENTAL DEFECTIVE.\*

GEO. B. COON, A. M., M. D.,

Tampa, Florida.

One of the most difficult things that confront the alienist in introducing his subject is to offer a satisfactory definition of what constitutes "insanity." Indeed, I have yet to learn of any definition of it which will withstand the assaults of lawyers in court, and many able men have become so hopelessly involved in attempting to tell the jury what insanity is that their testimony was utterly discredited before they left the stand. And yet the failure to discover a satisfactory definition is not the fault of the alienist, since lawyers and jurists have joined in the effort with no better result. Lord Blackburn, an eminent English jurist, speaking before the House of Commons Committee some years ago, said: "I have read every definition I could meet with, have endeav-

\*Read before the forty-fourth annual meeting of the Florida Medical Association at Atlantic Beach, May 18, 19, 1917.

ored in vain to make one satisfactory to myself, and I verily believe that it is not in the power of human ability to do this."

Of the scores of definitions offered, that of Peterson that "insanity is a manifestation in speech and conduct of disease of the brain" certainly has the merit of brevity, especially when contrasted with the 120-word definition of Spitzka.

Having disposed of the definition, we find that it was a very fitting introduction to a very obscure field. While the surgeon can demonstrate quite conclusively an abdominal tumor before operation, the internist definitely locate a gastric ulcer even on the lesser curvature, the pathologist show you a variety of bacteria whose existence as a factor in disease was considered by most men of a generation or two ago as purely hypothetical; while the subject of medicine itself has been slowly developing through a period recently shown to cover forty centuries, we find that but a hundred years ago the insane were supposed to be possessed of evil spirits, were chained in dungeons, and often exhibited to the curious much as are the animals in our zoo. I recently saw that the Superintendent of the Boston Insane Hospital in his report of 1820 proudly asserted that on warm sunny days many of the inmates were drawn out into the sun in their cages for a few hours, as evidence of the humane treatment accorded to the unfortunates under his care.

The study of insanity then is not only in its infancy, but it has to do with the functioning of an organ which, though the most important, is itself but little understood. I say "functioning" because, while in many organic cases due to emboli, clots, or constitutional diseases, we find brain lesions both gross and microscopical, coincident with unusual mental phenomena, there is an equally large class of cases in which mental aberration is marked and yet in whose brains no test however delicate can discover any lesion whatsoever.

Now, though alienists may be unable to

tell you what insanity is, as the scientists are unable to tell you what electricity is, they have nevertheless discovered many symptoms that precede and attend it, and many laws that govern it. With these as a basis many classifications have arisen, but attempts at psychological classification have proven so difficult that it has been questioned if it were not better to substitute the expression "groupings of mental disorders." Any stereotyped classification must obviously be a generalization and based on a consideration of a number of points, etiological, physiological, psychological, pathological and chemical, and though necessarily the importance credited to any of these will vary according to the value it has for a particular investigator, they must all be included in the group complex. Probably the work of Kraepelin has been most largely followed, but each alienist has introduced his personal preference and convictions, and it would be beyond the scope of this paper to go into the subject, since it is apparent that the system of classification will be followed which most appeals to the experience, judgment and preference of this particular alienist.

In considering the etiology of insanity one is struck by the frequent confusing of cause and effect, and by the use of psychic and somatic symptoms as causes of the psychosis instead of incidental or even the result of it. It is impossible to understand why the pathogenesis may be single, yet its manifestations multiple and varying in different proportions in different individuals, and why identical symptoms may follow causes entirely dissimilar. Nor is it possible, save on the basis of the personal equation, to explain why the nervous system of one should be affected by causes which fail to make any impression upon another, demonstrating that predisposing causes for mental instability exist in varying proportions. Some, for instance, have a narrow margin of safety and a mental shock or physical disease will carry them below the border line of sanity, while others have so wide a mar-



gin that no grief however great, no disease however severe can bear them down to this dividing line.

Fortunately for the physician and for the progress of mental study the tendency is toward simplification, and Kraepelin's demonstration of the natural history of some of the more common forms of insanity, pursuing them to their ultimate tendency, and showing that so-called different diseases might be different phases of the same disease, was a great advance.

From this rather lengthy introduction, I will pass at once to the discussion of certain symptoms and stigmata of insanity which may be of interest and practical assistance to the general practitioner.

It would be beyond the scope of this paper to differentiate between the psychosis of functional and organic origin, or to attempt any discussion of the alteration, whether chemical or otherwise, that must take place in the integrity of the brain in the large number of cases where no macroscopic or microscopic changes can be noted. I would, however, direct your attention to certain deviations from the normal which may be looked for and some of which will most certainly be found. For convenience we will divide them into objective and subjective signs.

It is unnecessary to say that there are no physical stigmata which are pathognomonic of insanity, and in cases where the deformities and asymmetries are marked they are usually to be associated not with curable forms of insanity but with degeneracies. Of course all are familiar with marked asymmetries seen in these cases and I pass them simply mentioning the irregularly-shaped head, face, ear, teeth, palate, sockets and eyebrows, and unusual growths of hair in unusual places, or conversely, its scarcity in accustomed places, etc.

Then we have disturbances of function, of both vital and special sense organs, and disturbances of a motor nature leading to countless changes of posture and move-

ments so often witnessed, which the average practitioner would hardly fail to recognize when at all well marked. Hence it is to the more subtle realm that we must call your attention, and to the alterations in personality and consciousness without which there can be no insanity.

One of the first signs of insanity is the weakening of conscious attention and the inability of the patient to direct his thought and will as he would like, and equally important the inability to inhibit irrelevant trains of thought. He may pass undue time in consideration of trivial matters or become so self-centered as to neglect important duties. Will, that power by which man is able to choose and direct his course, when various avenues lie before him, is as I have just said one of the first faculties to be impaired in insanity. And I would have you observe that this failure does not imply his inability to distinguish between "right and wrong," since the individual may have a correct understanding of his *duty*, and be as unable to perform it, as is the paralytic to extend his withered arm. When the patient then has lost his capacity to distinguish between "right and wrong" his insanity is already far advanced. I dwell upon this with especial emphasis because of its medico-legal aspect, since we are too prone to fix responsibility for their acts upon all who have the power to distinguish between right and wrong. Let us at this point also differentiate clearly between the possession of the "moral sense" inability to obey its dictates, and the complete lack of moral sensibility seen in the "unmoral" type. I will illustrate with two cases in my personal experience. Miss L., a wealthy and well-educated young lady, in my hospital, persists in bending her forks, spoons, breaking dishes and mirrors, tearing curtains and bedding, yet each time she comes to me and with tears in her eyes exclaims, "Doctor, I am so sorry I did that; I know it was wrong, I did not want to do it, it gave me no satisfaction and makes me feel bad, but

while struggling against it some power seems to force me to do it."

As an illustration of the unmoral type I present Miss B., of a wealthy and aristocratic "Back Bay" family in Boston. She is a stunning personality, yet ever so dignified in appearance that "mashers" never dared to make any advances, yet a short time ago she was discovered in a vacant room over my friend's store on West street in the embrace of a big negro who ran the elevator, both in an entirely nude condition. To the horrified exclamation of her father, "O why did you so disgrace yourself and above all with a nigger," she very innocently replied, "No white man ever asked me."

In appraising a man's sanity then you will determine his ability to make rational comparisons, to exercise the power of choice, his judgment, memory and his moral sense. This moral sense has been a matter of evolution as are the faculties already mentioned, and is doubtless the product of ages of human experience. It probably found its origin with prehistoric man, first as a protective expedient in the individual's relation to his family and tribe, then as a recognition of right and wrong, which being fostered by superstition, experience and heredity has finally become an organized function. This being the latest acquisition of man is by the law of deterioration the first to be lost, and as shown above, some unfortunates are born as completely bereft of moral sense as others of the power of sight and hearing. Hence it is not an uncommon experience to meet individuals, finely educated, widely traveled, brilliant conversationalists, so well informed and clever that you almost distrust your right to pass upon the sanity of men better educated than yourself, yet sooner or later they reveal the flaw in their moral responsibility. They are "unmoral" rather than "immoral," and often having no vicious traits or immoral appetites do not reveal them unless some improper suggestion is made to them when they will often accept as

readily as if the suggestion were perfectly conventional.

At a symposium on tuberculosis some years ago I heard Richard Cabot say that of the thousands of physicians who had entered his post-graduate course of Physical Diagnosis, not one in thirty could diagnose tuberculosis of the lung by auscultation, before the bacilli had appeared in the sputum and the disease was no longer an incipient case. The superintendents of four large State Hospitals for the care of incipient cases of tuberculosis agreed that not ten per cent of the cases sent to them as "incipient" proved to be so, while many were far advanced. The conclusion was drawn that the diagnosis should be made chiefly by the family and personal history of the case when combined with a narrow chest, persistent cough and failing weight. Such cases should be regarded as "incipient" cases without waiting for more convincing signs.

If this is true of tuberculosis, it certainly applies as well to mental disease. One should not wait until he can write in his committal paper as did one physician whose paper I had occasion to receive: "This case has, under my observation, passed through the various stages of mania, melancholia, paresis to dementia, and no longer has control of the ideational, rational or volitional powers." At this stage a child can make the diagnosis, but it should be our aim to recognize the earliest symptoms and by prompt action to avert, if possible, the impending break.

A large proportion of cases of insanity are not violent or homicidal, nor depressed or suicidal, nor do they reveal delusions, illusions or hallucinations of the special senses. To be sure they may have any or all the latter and not reveal them, or they may have none of the above symptoms and yet be unquestionably insane and fit subjects for committal; being woefully lacking in judgment, illogical in reasoning, lacking in self-control, in will power, and ability to

concentrate their minds. For the above reasons they may be unable to support themselves, or to adjust themselves to their environment, which is one of the chief tests of a sane mind.

Attending this weakened inhibition you may find an altered personality changes in emotional tone, imperative conceptions, morbid impulses, disorientation in time and place, displacement of the ego as manifested in self-abasement, exaltation or introspection; all of which may precede the commonly-recognized symptoms. Unfortunately, however, for the general practitioner, the picture is often obscure. Some cases presenting but one or two marked symptoms, and even these they may at times conceal, fearing that a free expression of their views may get them into trouble. Some appear simply suspicious and evasive, while others cooperate readily and only a routine point scale examination will reveal the defect.

I had one lady sent to me as insane who sat at my table three times a day for seven months without saying a thing out of the way, though I felt sure she had false hearing. One day she went out and tried to buy a revolver, tried to get the sheriff to arrest me and went to the neighbors for protection, saying that I was going to kill her and that she saw me getting the knives ready as she passed my office window. Another patient never said an insane thing for ten months, though I knew he was seething with delusions. At last he boiled over and a dozen stenographers could scarcely have recorded all his delusions.

Another rushed out of theatre one night and ran down the street shouting "bloody murder," and told the policeman, into whose arms he ran, that the "devil" was after him, but when he came to the hospital he was perfectly self-possessed, cheerful and jocular, disclaimed all of the ideas for which he was committed and never afterward revealed them while in the hospital. He would joke, play games, talk about current events, but never about these delusions, though I some-

times saw him evidently listening to voices when he did not know he was watched. When his friends said he was as well as he ever was and wanted to take him home, I told them I considered him a dangerous man, but as I could not tell them *what* his delusions were they became insulting. Finally he was allowed to go but only on the understanding that he was to be taken immediately back to New York where he belonged and never be allowed to come to Massachusetts again. At that time we discharged patients on sixty days' trial, the discharge becoming operative only after they had been out the full sixty days. This case did not go to New York as was promised and supposed that he was on sixty days' trial instead of absolutely discharged as was the case. He conducted himself with perfect propriety for sixty days and on the sixty-first shot a policeman.

Still another case, the widow of a Brigadier General in the Philippines. She was insane I knew, but two experts came out from the State Board of Insanity and finding nothing the matter with her advised her discharge. One week of freedom was sufficient to prove her mental condition and she was returned. Six months later she tried again to get her liberty and her guardian wishing to keep her under restraint sent out an expert for two examinations. The latter told me she might be insane and probably was, but that he could find no evidence of it, so I allowed her to go and in ten days she was in court again and the same expert had no difficulty in certifying to her insanity.

I had a classmate, a prominent lawyer in Boston, whose wife became insane and was committed to a large private institution there for two years when she appeared so much better that her husband took her home, though advised strongly not to do so. I saw her a short time afterward and she appeared perfectly normal, happy and cheerful, yet a short time later, without any warning, she shot him in the back of the head as



they were returning from the station, killing him instantly.

I speak of these cases as illustrative of the ability of the insane to conceal delusions, and to show the danger in temporizing with any case who has delusions of persecution and false hearing especially if he has ever uttered a threat. It should also make one cautious about pronouncing a case sane, after a brief examination, especially if such case has had a history of recent delusions of a persecutory nature, since it is altogether likely such delusions are either concealed or dormant and may at any time overwhelm their possessor and impel him to some violent act.

Now the general practitioner's relation to the community is a peculiarly intimate one. Not only are troubles of a medical nature referred to him, but he is often the family confidante to whom matters of a personal nature are taken for advice. He knows the personal histories and family secrets of most of his older cases, he knows their very hopes and fears, and is supposed by them to know something of every field of medical activity. He, therefore, occupies a position of peculiar responsibility to his patients. Often called to attend trivial ailments, he may discover some serious and unsuspected disease; as when examining a case of bronchitis he discovers a small lump in the breast and refers the case to the surgeon while there is still chance for a radical cure. He may suspect eyestrain as a cause of headache and refer his case to the oculist, while if the trouble be due to adenoids or a nasal spur, he sends it to the rhinologist, etc. He should be equally alert to note mental symptoms, none the less important because obscure, and to give his patient every chance that an early diagnosis brings.

He should warn the parent to retard the activities of the too precocious child, lest its vital forces fail and it fall a victim to a psychosis which is more blighting in its effect than poliomyelitis.

He should note the "backward child." A

certain proportion of these may have the cause of their backwardness removed. The majority, to be sure, are congenitally deficient, but their condition is hardly less important, since most of these cases are susceptible to mental training up to a certain period, and may be taught to become self-supporting. These few years then before the child reaches the apex of his mental development are of tremendous importance in fitting him to do some self-supporting work. None can tell when this mental development may cease, whether at eight or ten or twelve. Hence, it becomes the more important for the child's happiness and welfare that all possible be crowded into the limited time accorded it. When this period of development closes, it seems impossible to teach the child another act, though it can do quite well the things it has already learned.

Be watchful of the child who shows a disposition to avoid his playmates, to be morose, unhappy, dissatisfied, and in general unable to adapt itself to its environment.

Then there are the chronic alcoholics who seem prone to the delusion that their wives are unfaithful. Many a man with brain afire with drink has returned to his home to kill his wife for her supposed infidelity.

I think that one of the most pathetic types to deal with is the paretic, with euphoria and expansive ideas. Friends may note the change in personality and attribute his exhilaration to convivial habits. Men may take advantage of him in trades, believing him responsible, and often times he plunges into some utterly impractical scheme, dissipating a large property, and leaving wife and children penniless before his real condition is suspected. Unfortunately in these cases the law offers little redress even though proof be deduced of his mental incompetency at time of the transaction. I had a friend who was superintendent for years of a large asylum north until his health broke down and he resigned. He had saved nothing from his income, but shortly after his resignation he

received \$15,000 from an endowment insurance policy. While in the city one day a promoter induced him to invest \$7,000 of it in a scheme which he would not have considered for a moment in his right mind. At home that night his wife induced him to go to the city and get his money back, but upon his return the promoter got the rest of his money, none of which was ever recovered, and the doctor died a few weeks later of paresis, leaving his family destitute.

A particularly dangerous type is that of the eccentric, who is unsocial, suspicious, and especially if he thinks people are down on him or talking about him. He is quite inclined to brood over his fancied grievance and to magnify them, and one never knows when the power of self-control will take to itself wings and some tragedy result, since such cases often keep their own counsel until ready to strike.

If you know of a case in your practice who has recovered from an attack of mental disease, for which there was no known cause, you must remember the possibility of a recurrence and have interested parties on the watch for any symptom suggesting the return of the trouble. When you are dealing with parents either of whom impress you as slightly below par mentally, look for signs of degeneracy in the children and if found, keep a watchful eye on their health and progress. And let me in this connection say that there are many men walking your streets today and raising families on your country farms who pass as of normal intelligence, being superficially bright and yet who could not meet the requirements of the normal twelve-year-old child. There are numerous degenerates who are mentally and morally irresponsible and who should be immediately placed under restraint, not only for their own good but for the safety of the community, who will be allowed to roam at will unless they commit some fiendish crime, whereupon the poor brutes will probably be lynched or suffer execution in due process of law. Mind you, I do not assert that every

criminal is insane, but I do maintain that an astonishing percentage of them are the offspring of degenerate parents and heredity and environment have conspired to produce a diseased, misshapen thing from which all healthy minds instinctively recoil. The accident of birth has robbed them of the high ideals and well-balanced faculties which govern our acts, and I feel assured that if mental and moral obliquities were as apparent as physical deformities, these degenerates would arouse our deepest sympathies, and we could better understand many of their acts which now surpass our comprehension and exhaust our patience.

Gentlemen, your experience has made you apt students of human nature. You meet a great variety of individuals under most intimate conditions and you can safely predict what will be the conduct of a normal individual under certain given circumstances. Then when you see individuals departing from what you consider a normal process of reasoning, endeavor to discover and correct the cause. If you will consider it your duty to observe closely such of your cases as seem to be having an unequal fight in adjusting themselves to their environment, and you will give helpful hints at the proper time, urging proper methods of treatment, you may avert a tragedy or scandal, and a lifetime of humiliation on the part of the patient. I have had under my care many murderers who have killed their wives, mothers who had killed their children during an acute psychosis, who, had they done a less violent act, would be at home today. But, because no one dares take the responsibility of their care, they still linger in asylum wards, a prey to the most painful memories. Had a watchful eye taken these cases early in hand, and placed them in some quiet place until the acute symptoms had passed, they might be enjoying life at home today with family circle unbroken.

I sometimes think that it was a very beneficent provision of nature which has limited our physical development to a cer-

tain prescribed scale. In a measure it seems to put us all on the same plane in the struggle for existence, though mentally men may differ as widely as the valley and the mountain top. I fear, however, that it has diverted our attention to the external and material, the visible and tangible things, and tends unduly to exalt the study of the body to the detriment of the study of the mind.

When one considers the marvellous capacities and accomplishments of the human brain, an organ that can conceive and execute vast engineering feats, build skyscrapers and great ships, which can tunnel mountains, span large rivers; which, seizing upon the discovery of a Franklin, develops and applies it till we have the electrics, the electric light, the Roentgen ray, the wireless; which discovers in sound certain physical laws and proceeds therefrom to develop the telephone and phonograph; which challenges the law of gravity, permitting men to soar among the clouds or cruise beneath the waters of the sea at will; which can produce the harmonies of a Beethoven, the poetry of a Shakespeare, the oratory of a Demosthenes, and the philosophy of a Plato, one can but marvel that the study of this wonderful organ, the only one which makes existence worth while, has received no consideration save within the span of life of men now living, while those best informed tell us that we all have latent capacities of whose existence we do not dream, and that our ultimate possibilities stretch far beyond the achievements of the superman of today.

The study of mental disease may be difficult and often unsatisfactory, but it is both unscientific and unprofessional for the general practitioner to disclaim all knowledge and interest in it because of these difficulties. The public looks to him to protect its mental as well as its physical health, and all must admit that the former is the more important. I urge you, therefore, to recognize and assume this responsibility. Do not wait until the children on the street make the diagnosis and the whole community demands action

on your part. Do not demand evidence of violent conduct and delusions before you are convinced of insanity, especially if there is evident irresponsibility, defective judgment, will-power and self-control. Advise the early appointment of a conservator in cases of paresis and beginning senile insanity, before they have opportunity to dissipate their all, and see that some of these poor degenerates are put under restraint, not only for their own good but for the safety of the public. I could hardly have a more pathetic illustration of the need of this than in the trial in Tampa this week of a seventeen-year-old boy for murder. How long shall we allow mere children to suffer the extreme penalty of the law while we neglect our manifest duty! How long continue to fill our cemeteries and our jails with irresponsible unfortunates, because we have failed them in their hour of need!

It is my earnest hope that we may soon have in this State a well-organized society for mental hygiene for the instruction of the laity in these most essential points. The need is great, and the opportunity ours, to contribute more to the happiness and welfare of the citizens of this great commonwealth, in this manner, than through any other field of human endeavor.

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#### THE VENEREAL DISEASE PROBLEM.\*

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Tuberculosis, malaria and the venereal diseases form the most vital questions before the public at present along the line of preventive medicine. With the eradication of these plagues a large economic saving can be given to the community, and coincidentally better health and living conditions.

It is presumed that the control of both malaria and tuberculosis is but a question of

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\*Read by title at the forty-fourth annual meeting of the Florida Medical Association at Atlantic Beach, May 18, 19, 1917.



time, due to the education of the public by health authorities, private organizations for their suppression and a constant agitation fostered to a large extent by the medical profession.

Tuberculosis, at least, has the advantage in most communities of effective free clinics and public sanatoria for the diagnosis and treatment of the disease.

Malaria, through an exact knowledge of means of transmission, the simple and universally applicable methods of prophylaxis, has in a large measure been reduced in progressive communities within the past decade, and will be still further reduced in the near future, probably without the aid of special legislation.

On the other hand, the venereal diseases, until very recently, were not to be mentioned in polite society. Their presence conveys a social stigma which is true of no other disease, and the unfortunate patient due to this public opinion either resorts to self-medication or the advertising quack, retains as best he can his secret and is poorly and ineffectively treated with disastrous results to himself and unfortunately to others, usually innocent victims of public prejudice.

The problem is not one purely of medical standards, but is so wrapped up in sociological and economic questions that it is difficult to separate them.

There are few clinics which treat these cases or can afford to treat the majority of indigent patients effectively; very few hospitals, even in our largest cities, will admit patients with a diagnosis of either syphilis or gonorrhœa.

Until the public realizes that these diseases are preventable and is willing to accept the fact that these patients should not be treated as social outcasts, but as patients needing medical attention until cured, little headway will be made against their ravages.

This will require an educational campaign comprising not only the public at large but to a certain extent the medical profession

and health authorities as well. It may necessitate sociological work of a vastly different sort than has been done in the past; it may necessitate the complete remoulding of our institutions for the treatment of these diseases. Campaigns of this sort are slow, they must be undertaken by people trained to this sort of work, enthusiastic and capable of standing discouraging and usually sneering public opinion.

The sociological aspect of the problem is hardly up for discussion at this time. It will be necessary to point out, however, that no campaign which looks only to the elimination of the social evil will get very far towards the eradication of venereal disease.

Those countries which have attempted regulation of prostitution have admitted that not only have the measures been unsuccessful in stamping out the disease but they have not gone far towards either regulating or decreasing the social evil. In this aspect of the problem education of the young man seems to be the best hope that we have at present in decreasing the liability of infection. There are no doubt laws regarding the social evil in existence, their strict enforcement might possibly help some, although experience in American cities that have done away with the segregated district tend to show that immorality has been little if any diminished.

Within the past few years, however, there have been certain activities, sporadic for the most part, which have shown that the public has awakened, at least partially, to the fact that they have a tremendous responsibility not only to this generation but to succeeding generations.

The introduction of the Wassermann reaction, the Report of the British Royal Commission on Venereal Diseases, the agitation in other States show that within a short time there will be a crystallized concerted action against this plague.

When the State Board of Health made the Wassermann reaction part of the routine work of the laboratories the entering wedge

was introduced, for I doubt if anyone will question the statement that an exact and early diagnosis is essential to the effective treatment of the disease. It serves, or should serve, the purpose also of enabling the doctors to follow the treatment of their cases as well as affording a differential diagnosis, invaluable in obscure conditions. The work of the past year has brought out several striking points and it is on these that the present discussion is based.

We have received in the central laboratory some fifteen hundred specimens from the city prison farm, from people who have come under the control of the courts through some infraction of the penal code. Of these approximately 45 per cent have given positive reactions for syphilis. Here then is a comparatively large class of people, considered dangerous to the community because of their attitude towards society. It has been shown that they are doubly dangerous, due to their infection and the probability of their transmitting that infection. The average term of their imprisonment is sixty days, too short to allow of adequate treatment, yet under proper supervision treatment could be started, and by changing the existing laws, these prisoners could be kept under the jurisdiction of the court under parole until that treatment was completed and they were no longer dangerous to the community from a health standpoint. Some such action might be desirable and I believe would be practical.

For the Florida Hospital for the Insane we have examined 240 specimens, 20 per cent of which were positive. Inasmuch as these patients are committed for definite symptoms of mental incapacity for an indefinite period under close medical supervision until they can be returned to the world cured, or at least much improved, it is reasonable to assume that that phase of the problem is adequately taken care of.

The real problem is the public at large, those cases which come under the supervision of the general practitioner. Statistics

available at the present time indicate a variation of from 5 per cent to 90 per cent of positive examinations, depending upon the class of people from which the specimens are taken.

Massachusetts, in its recent report, gives 5 per cent as the percentage of population for the entire State infected and notes that these figures are possibly too low.

A recent publication from the United States Army among recruits in the Middle West shows 17.6 per cent infected for some 17,500 examinations.

The true figures apparently lie somewhere between 5 per cent and 20 per cent of the entire population infected. Our figures here in the laboratory from a class of people suspected of being infected give about 30.6 per cent positive reactions, undoubtedly too high, but still sufficiently impressive to show the size of the problem with which we have to deal.

Unfortunately a considerable percentage of these cases are inadequately treated; through ignorance as to the effects of the disease, through inability of members of the profession to keep them under control, through lack of financial ability to take a course of treatment covering a period of eighteen months to two years and to the prevalence of quack specialists and "patent medicines" guaranteeing a cure in from six days to one month.

Whether or not legislation is desirable at this time is a question; whether the public is ready to accept a drastic law such as that recently enacted in Western Australia is doubtful, but that something looking to the amelioration of the condition is desirable is unquestioned.

"The Western Australia Act compels patients to submit to treatment until cured. It does not have the objection of notification. If the patient does his part, the act protects his secret; and even if he does not submit to treatment, his secret is protected so far as possible by making all legal proceedings private. However, it does not



waste any great amount of sympathy on the miscreant who is indifferent to his duties of getting himself cured."<sup>1</sup>

For the present it would seem better to confine our activities to an educational campaign of a very comprehensive sort, to bettering the conditions in regard to medical practice in the treatment of these diseases by eliminating the advertising quacks and the prohibition of advertising cures. Above all, whatever steps are taken two points must be remembered; so far as possible the general practitioner should be protected; the secret of the patient should so far as possible be protected; yet adequate means of treatment should be provided for all patients.

It is customary to make communicable diseases reportable. In regard to venereal diseases some States require the patient's name and address to be furnished, some require an anonymous notification. It would appear that the best authorities regard this of very doubtful value. The British Royal Commission reports adversely on this measure<sup>2</sup> saying:

"We think it clear \* \* \* that if a case for notification of venereal disease is to be established it must be based upon the assistance which notification would afford to the treatment of the individual, and the consequent protection of the community, and not on the ground that it would facilitate general preventive measures \* \* \*. The main objection which has been urged against notification of venereal disease is that it would actually do more harm by deterring people from seeking treatment, and by driving them more than ever into the hands of unqualified persons."

I am not sure that I entirely agree with them on this point. If the State is to control the situation, or is to give its assistance in controlling the situation, it has the right to know just how much it is required to do. However, I do agree that at present so far as the local condition is concerned, notification would retard rather than advance any campaign which may be undertaken. Until

the public is fully aware of the dangers of the diseases, any campaign looking to its prevention should hinge on the following conditions:

1. Adequate opportunity for an early diagnosis.

A case diagnosed properly and early in the disease increases the patient's chances of an early and complete cure. While it is an invaluable benefit to the individual, it is also a great benefit to the community through the removing of one focus of infection.

The routine examination of blood in the State Board of Health laboratories offers this opportunity and I believe that a certain number of patients lend themselves more readily to treatment after the diagnosis is made by serological than by purely clinical methods, and this is especially true where the course of the treatment is followed closely by examinations of the blood at stated intervals.

2. Adequate opportunity for universal effective treatment.

This would necessitate increasing the clinics and dispensaries in most communities and in some would require the founding of them. It would also necessitate ample hospital facilities for cases needing hospitalization. Even if the means of effectively treating indigent cases were at hand, there are a large number of cases neither indigent or rich who are able to pay something for this treatment. This class of patients usually take treatment until their finances are used up. They remain uncured and a source of danger to the community, not infrequently an expense to the State in the later stages of the disease.

3. Education of the public.

Educational campaigns undertaken in a half-hearted fashion, or in inexperienced hands, are worse than useless. The teachings should be concise and accurate, any books or pamphlets used should be written by or at least have the approval of men experienced in medical teachings.

#### 4. Education of the medical profession.

It would seem, at least to those of us who handle a large number of specimens in the laboratory, that more stress should be laid on venereal diseases and their treatment in the medical school. More stress should also be laid on the interpretation of the Wassermann reaction, and especially on those conditions in which it is inadvisable to take blood for testing.

It is difficult, if not impossible, for the laboratory man to interpret his results when the clinical history is refused and more especially when the conditions under which the blood is taken is unknown. More cooperation and more information in these matters make for better efficiency and greater satisfaction both for the physician, the laboratory man and the patient himself.

<sup>1</sup>"The Venereal Disease Problem" (Editorial), Journal American Medical Association, Feb. 24, 1917, Vol. LXVIII, No. 8, page 639.

<sup>2</sup>"The Venereal Disease Problem" (Editorial), Journal American Medical Association, Feb. 10, 1917, Vol. LXVIII, No. 6, page 463.

### THE VALUE OF FRESH COW'S MILK IN INFANT FEEDING COMPARED WITH ARTIFICIAL AND PASTEURIZED MILK.\*

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My object in bringing this subject before you is to arouse a train of thought in the medical profession that will result in bringing into practical operation certain material factors pertaining to the feeding of infants with cow's milk that will establish better nutrition for children and more practical and economical conditions for the people of our country in general.

Clean fresh cow's milk is the second most perfect food for infants, and if there is a substitute to the pure product in nourishing children, it is unknown.

\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.

Clean fresh cow's milk is a complete food capable of nourishing and maintaining normal body growth.

Such milk is a natural complete food consisting of good proteins, suitable ash mixture, sugar and fats, also two chemical substances of unknown character, termed "vitamines"; one is contained in the butter fat, the other in skimmed milk.

When milk is taken into the digestive tract the action of the vitamine elements in fresh cow's milk is *the something* or the *activating substances* that act on the proteins, ash, fat and sugar, causing these known chemical elements in milk to readily stimulate cell activity in the body and through the influence of the vitamine elements of milk are transformed into energy and life.

Should clean fresh cow's milk have too much protein, add sufficient water to regulate it; too much butter fat, separate enough fat to regulate it; too little sugar, add enough sugar to reach the required amount. All the known chemical elements of *fresh cow's milk* can be regulated to meet the needs of individual children. The vitamine elements being present, cell activity is stimulated and the normal body growth is maintained.

It has been amply demonstrated in the past and is being demonstrated now that clean fresh cow's milk can be produced at a fair margin of profit to the producer and at the same time delivered to the consuming public in range of economy for consumption—being delivered bacterically clean and otherwise clean, having an economical food value in proportion to cost of any article of food and of greater nutritional value than many of the regular articles of food that are routinely consumed.

Pasteurized and sterilized milk are artificial products, and the term "artificial milk" in the text of this paper only refers to such milk as is treated by heat. Pasteurized milk is milk treated by heat at 145° Fah., for thirty minutes. Sterilized milk is boiled milk.

The vitamine elements are materially changed by this heating process and hence the known chemical elements are not transformed into life as efficiently or as economically in the feeding of children. The action of heat in sterilizing milk materially reduces the efficiency of the vitamine elements which are so essential to nutrition, and changing a natural food product into an artificial food product of lessened nutritional value; and knowing that medical men are recommending pasteurized milk indiscriminately, causes one to pause in astonishment at such teaching, compared with other more progressive and rational measures of meeting the ends of economy and sanitation in other problems.

That pasteurized milk has been robbed of the life influencing "vitamine elements" by heat is a chemical fact, and that pasteurized milk when fed continuously will produce malnutrition in infants is a physiological fact. Therefore, that you may see that the "vitamine elements" are most essential to nutrition, the following comparison in plant nutrition is offered you: Take a box of earth, give it the known elements of plant food, namely, nitrogen, phosphoric acid and potash, water and light; now transplant a plant in this box and watch it grow vigorously. Also take another box of earth, heat it or sterilize this earth and do all the rest that was done for the first plant, and you will see the plant in the second box dwarf into a state of malnutrition. The reason this plant does not thrive in the second box of earth is, the soil bacteria, the elements in the earth that are analogous to the "vitamine elements" in fresh milk, have been killed by heating or pasteurization.

Through the energies of the certified milk producers only last year was a general enforcement of pasteurization of all milk prevented. Why pasteurized milk? Answer: To kill the vicious types of germs.

Dr. Emmett Holt, of international fame on infant feeding, stated in his address in helping the certified milk producers to de-

feat the measure, "Pasteurization of all milk," "That pasteurized milk produced malnutrition and scurvy." In print today nearly every journal is crying pasteurized milk, medical societies cheer along papers on pasteurized milk, and politicians and many health boards are demanding sterilized milk. The answer to all of them: Better the economical conditions of the masses of people, and stop encouraging *artificial foods* that will cause malnutrition.

The medical profession should prescribe, endorse and encourage the production and use of clean fresh cow's milk, create public sentiment that it is the *milk of standard nutritional value*; and I am warranted in saying that for the ends to be gained, if it cannot be obtained otherwise, go to the producers and encourage its production and if no other recourse, produce it ourselves. The call of the day is efficiency in our profession as well as to all others.

The hour has arrived that medical men *read the signs* demanding better conditions on the farm, the home and in the school. The elementary principles underlying nutrition are being abused.

The love of work, the conservation of energy and the *vital bond of integrity* that gives confidence in man in this rapid pace we are living, invite the sturdy manhood of the medical profession to live in a closer relation to the masses of people, that the natural elements of a progressive people may be developed and conserved. I trust that from these thoughts a renewed energy and a determined resolution will get hold of every doctor and go with him in the *homes, the fields, the schools* and in *all places* of society and make a study of actual conditions that will enthuse and encourage an appreciation of cleanliness of milk and all food products.

When our activities thus mingle with the working conditions of the masses of people, we may hope to enjoy the principles of our sublimest aim in the science of medicine, viz., the prevention of disease.



*Summary.*

That clean fresh cow's milk is a natural complete food, capable of producing normal body growth when fed to infants.

That it contains the known chemical elements in proportion necessary to maintain life.

That the vitamine elements in fresh cow's milk exert a distinct influence on cell growth by readily converting the known chemical elements in milk into life, when consumed as food.

That the food value in clean fresh cow's milk bears a relation to the medical profession in degree, that it necessarily concerns the medical profession directly as well as the people in general.

That the proper nutrition of infants and children depends on clean fresh cow's milk.

That sterilized and pasteurized milk are artificial foods.

That the process of heat materially changes the food value in milk by lessening the action of the vitamine elements.

That malnutrition will result in infants fed on pasteurized and sterilized milk.

That the proper nutrition of children is of first consideration, and the value of clean fresh cow's milk in infant feeding is the article of our chief reliance.

That to secure the proper article or articles of nutrition, the conditions of our country necessarily need the activities and influences of the entire medical profession to the degree, that the material conditions of the people will be stimulated to an appreciation of cleanliness in the production and consumption of clean fresh cow's milk, and in all articles of food that underly the *nation's greatest need—proper nutrition.*

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#### ABDOMINAL PREGNANCY.\*

GERRY R. HOLDEN, M. D.,

Jacksonville, Fla.

An abdominal pregnancy is a pregnancy in which the development of the uterus

takes place in the abdominal cavity, outside of the uterus or tube, but within the fetal sac. The condition is interesting on account of its rarity, its gravity, its differential diagnosis and its treatment.

Abdominal pregnancies originate in ruptured extrauterine pregnancies in which the fetal sac is not ruptured, the placental site not greatly disturbed, and the fetus itself not killed at the time of rupture.

As a rule, when an abdominal pregnancy ruptures or aborts, the entire sac is separated from the tube, or separated to such an extent that the fetus dies. When this does not occur, the development of the fetus may go on for a certain period of time, occasionally to full term. The cases in which this occurs are said to be always tubes which have ruptured into the folds of the broad ligament, or at least under the peritoneum. Apparently the tension of the peritoneum checks the hemorrhage and holds the sac in its original position enough to keep the blood supply intact.

We must consider first the relations of the placenta, and then those of the sac. The placenta, originally attached to the inside of the tube, grows out as the pregnancy advances, attaching itself to all the parts or organs with which it comes in contact. A maternal blood supply develops itself in those parts on which the placenta lies in a manner similar to that in the normal uterine cavity. In the latter stages of an abdominal pregnancy the attachment is very extensive, the placenta overrunning the uterus, broad ligament, bladder, pelvic walls, etc. The fundamental difference between the maternal blood supply in such a condition and in a normal pregnancy is that in the abdominal pregnancy there is no mechanism to constrict the blood vessels of the maternal site after removal of the placenta as the muscle offers in the normal pregnancy.

The development of the sac is interesting and important. Delicate and thin at time of rupture, it later becomes well organized and frequently very thick. There is much inflammatory reaction about it and the thick-

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\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.

ness apparently depends on the extent of this inflammation. The sac is always extra-peritoneal, but as it develops, it pushes its way up into the abdominal cavity, carrying the peritoneal fold in front of it, and becomes practically an abdominal structure. On account of the inflammatory reactions, it often becomes very densely adherent to the surrounding structures, especially to the intestines which lie above and behind it. The uterus and pelvic organs are pushed to one side or the other, and are often densely adherent to the sac.

The early symptoms are, of course, those of an extrauterine pregnancy, ruptured, with, perhaps, less evidence of abdominal hemorrhage than in the typical case, and with absence at times of vaginal hemorrhage. After the initial symptoms of rupture, the abdominal mass goes on developing. Recurring attacks of pain, of shock at times and vicarious vaginal bleeding mark the course of the case. The development of the tumor may at first be asymmetrical, but in the latter months it is very like that of a normally pregnant uterus. Pelvic examination may reveal a uterine fundus separate from the mass or it may be so adherent to the mass that it cannot be distinguished from it.

If the fetus goes on living, the fetal movements and the heart sounds are heard clearly. At or near the time of full development of the fetus uterine contractions occur, the so-called "false labor" and the decidua is cast off from the uterus. The fetus then dies. The further course of the condition is variable. The tumor may shrink up some at first. If no infection occurs, the sac and fetus may mummify, or finally become calcified, as in one case reported by Dr. Kelly. Infection and death, (if not operated upon,) are more likely.

The differential diagnosis is usually easy. In the early months it may be confused with an ordinary ruptured extrauterine pregnancy, in the later months with a normal uterine pregnancy; while after the fetus

dies, it must be differentiated from an abdominal tumor.

At the very first there may be no way of differentiating it from an ordinary extrauterine rupture, though an absence of vaginal bleeding would make one suspicious of an abdominal pregnancy. Later, as the mass regularly increases in size and assumes an isolated tumor shape in the abdomen, the diagnosis becomes clearer.

In the later months it is diagnosed from an ordinary pregnancy by the history, the clearness with which the fetal sounds are heard, and the fact that the normal uterine cavity can be demonstrated by the uterine sound distinct from the mass.

When first seen after the fetus dies, if no history could be obtained, diagnosis might be difficult. The findings, coupled with the history, ought to easily clear up the diagnosis.

The treatment varies according to the stage of the condition, i. e., whether seen at time of rupture or in first few months; (2) in the later months with a live fetus, or (3) in the later months after the death of the fetus.

At the time of rupture it is treated, of course, as an ordinary extrauterine pregnancy and in the first few months we can often remove the sac entirely, ligating the broad ligament vessels which supply it. After the first few months the sac cannot be removed in that way, the attachments to the pelvic walls and viscera being too extensive. The sac must, therefore, be opened and the fetus and amniotic fluid removed. If the fetus is then dead and the placenta and maternal circulation thrombosed, the process is simple. The thrombosed placenta can be easily lifted out and no hemorrhage, of course, will follow. But with a living child, or with a child dead so short a time that the maternal circulation has not thrombosed, the danger is very great. Removal of the placenta from its site gives rise to a terrible and uncontrollable hemorrhage from the maternal circulation. There is nothing to

clamp down on the maternal vessels as the uterus does in such conditions in the normal pregnancy. In these cases, therefore, no attempt should be made to remove the placenta. The cavity of the sac should be packed with gauze, the edges of the sac brought together, reducing the opening made into it, and then the edges of the sac sewed to the lower part of the abdominal incision. After a few days the maternal circulation will have become thrombosed and the placenta lifted out through the opening left in the incision. Healing and recovery is uneventful, as a rule, after such procedures. In those cases in which the placenta can be removed, the sac should be treated in the same way.

I wish to report two cases of abdominal pregnancy treated by operation:

*Case 1.* Mrs. N. A., of Lonaconing, Md., first seen June 28, 1905, at Johns Hopkins Hospital. (J. H. H., Gyn. No. 12207.)

Patient forty-one years old, five children, youngest fifteen. Last menstruation one year before entering hospital. Patient thought at first that she was normally pregnant. In third month of pregnancy had a sudden attack of severe abdominal pain, accompanied by much shock. Recovered in a few days. Two weeks later a second similar attack. Ten days after a third attack. From then on until about ten weeks before entering hospital condition was fairly good, abdomen increased in size as in a normal pregnancy and patient and doctor supposed that she was normally pregnant. Ten weeks before entering hospital had severe pains resembling labor pains, lasting about six hours. After these subsided, there was some bloody vaginal discharge. A few days later fetal movements, which till then had been marked, ceased and the abdomen did not increase any more in size.

On examination the abdomen was distended by a tumor resembling a full-term pregnancy and a fetus could be indefinitely mapped out. No fetal movements, no heart sounds or placental bruit. On vaginal exami-

nation there was a profuse, dark, bloody vaginal discharge. The cervix was pushed up behind the symphysis and the fundus could be mapped out distinct from the tumor and rotated to the right.

At operation the sac was found densely adherent to the testines at the back. The walls were very thin in places and showed marked evidence of inflammatory reaction. The sac was opened, about three pints bloody amniotic fluid evacuated. The placenta was entirely thrombosed and the dead fetus and placenta were removed without any hemorrhage. The sac was treated as described above and the patient made an uneventful recovery.

The fetus was a full-term child, female, weighing 2,370 grams. It had apparently been dead about two months, there was maceration of the skin, degeneration of the brain.

*Case 2.* Mrs. L. B., first seen in consultation with Dr. J. A. Simmons, of Arcadia, on March 11, 1917.

Last menstrual period in December, 1916. In January, 1917, had a severe attack of abdominal pain associated with shock, and the condition diagnosed as extrauterine rupture by Dr. Simmons. He advised immediate operation, which was refused. From then on she had a number of attacks of pain and severe shock, her condition at times being very critical. Bloody vaginal discharge at irregular intervals.

When first seen in March there was a boggy mass in the pelvis lying more to the left side. Condition was not then recognized as abdominal pregnancy. General condition so poor that we advised against operation.

Patient gradually improved and operation was finally done on April 21st. At this time a presumptive diagnosis of abdominal pregnancy could be made. The mass had increased very much in size, extending nearly to the umbilicus, was cystic in feel, did not fill up the pelvis laterally, and a fundus could be with difficulty distinguished from the mass.



At operation the sac was found definitely extraperitoneal. It was thin and degenerated in the upper part.

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### THE NEGLECT OF MASSAGE THE REASON OSTEOPATHS AND CHIROPRACTORS EXIST.\*

FREDERICK J. WALTER, M. D.,  
Daytona, Fla.

Do osteopaths and chiropractors get results? They most certainly do, and some very good results. The existence of these branches of treatment specified as complete systems within themselves is largely due to the neglect of the medical profession to value and prescribe massage when it is indicated, and is partly due to the fact that if massage were desired, it would be difficult to get good masseurs. Moreover, massage is not taught to any great extent in our medical schools. Reference is made to it in a general way in the course in general therapeutics, but no time is given to the detail. Schools do not exist which give this instruction as a nurse gets her training even in hospitals. It is a recognized fact that once a man gets to be a fairly good masseur, good results follow, and he begins to prescribe with an exalted idea that he knows about as much as the physician. Of the mechanical side he soon from experience knows more, but for him to be able to give the indications and prescribe for definite effects and results would call for knowledge impossible to have without an understanding of histology, physiology, pathology and the course of disease. In order to get good fees, it is necessary to dignify massage with some other name and also call the chiro-masseur "Doctor." He presumes without proper foundation to diagnose, prognose and prescribe, and assumes knowledge beyond that of a masseur and scorns on being the

tool of another man. Of the better osteopathic schools this is not exactly true, for they are adding to their courses of instruction many things that a real physician had and they will continue to require more and more, but always far behind the better medical schools. Of the chiropractors unfortunately the same can not be said. After a man has had some experience in these limited branches, he soon finds his great mistake even if honest in the beginning in the belief that his system is complete. In the writer's five-year experience in sanitarium treatment, with good assistant masseurs, it was found that massage was equal to most other measures in importance. The cults soon find that a larger knowledge of medicine is necessary and ask legislators to give them the right to do minor surgery, give hypodermics, anesthetics to antidote poisons, and some want to give serums and include most anything a Regular prescribes, without having had college instruction in these things. It is for us to post ourselves on the good and bad effects of massage and to start schools of instruction in massage for physician and masseur along with the medical course in the hospital work as part of every medical course, and in this way give no excuse for such cults having an existence. Of course the admission that massage gives the results obtained by the cults mentioned would spoil their whole scheme of practice, but so long as good masseurs under the direction of intelligent physicians are not to be had, the osteopath and chiropractor will succeed to a limited degree. There is no reason why a masseur should not be taught to adjust spinal defects where they exist! The chiropractor is required to have no preliminary education and puts out his sign after a few weeks' course by mail in many instances. We all know that this particular matter of dislocations of the spinal vertebra has been overworked and made the plausible excuse for their system. Without general manipulation, pounding, pinching, stretching, etc., they would produce very

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\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.

little effect upon their patients physically or mentally. We are asleep as a profession if we do not inform ourselves more extensively on massage and its splendid position in medicine. Massage is as old as the Romans, but what other method of treatment has held its place so well? This should speak more for it. The writer has found it very hard away from a sanitarium to get certain results without this aid in treatment. It has been difficult to get a masseur when most needed. It is as important to know when it should not be given as to know when it is indicated. After a proper course and examination, a masseur should receive a certificate which should enable him to register as a masseur, and these men and women should everywhere be readily accessible to the profession.

In Sweden there is no need for these cults and the masseur fills the field completely and is second only to the trained nurse.

In asking the question in a medical society why massage was not prescribed more extensively, the reply came forth that it was not taught and that masseurs were not to be had.

In prescribing massage the physician should know that he is dealing with a method of treatment which can be made a stimulant or a sedative in action. Its effects are primarily upon the circulation and secondary upon the glands, muscles and upon deposits. The disease with its complications and tendencies must be kept in mind, the vitality of the patient and his powers of reaction should be studied and watched. This being beyond the uninformed mind of the masseur, he should be as submissive to instruction as the trained nurse is carrying out details. Treatment given under such a system can be regulated better than that given by the man who "treats chronic cases only" and is largely out for the money there is in it. Would it not seem better to deal with the cults in this way and not try to legislate them out of existence? The more we legislate the more we will have to. As a

member of the legislative committee of this society, the matter has been given much consideration and thought and it is with the hope that the situation will receive the serious consideration of the medical profession.

### PROPAGANDA FOR REFORM.

AMBRINE.—Ambrine is a French secret preparation that has been on the market for many years. It has recently come into prominence through sensational articles in the lay press. For all practical purposes it is solid paraffin to which some material has been added to make it adhesive and more plastic. For use it is heated until liquid and then applied to open wounds and burns, forming a relatively impervious dressing (*Jour. A. M. A.*, April 7, 1917, p. 1057).

CORPORA LUTEA (SOLUBLE EXTRACT).—The Council on Pharmacy and Chemistry reports that "Corpora Lutea (Soluble Extract)" marketed by Parke, Davis & Co. in the form of ampules for hypodermic administration is ineligible for admission to New and Nonofficial Remedies, because it is a secret preparation advertised under extravagant claims. No statement of composition is made beyond the indefinite claim that it is an aqueous solution of "soluble Corpora Lutea Extract," each ampule corresponding to 0.2 gm. desiccated gland. How these soluble products are obtained, whether they represent all the water-soluble principles, or whether some have been eliminated is not stated. The claims made for the action and uses of the preparation do not make clear the essentially experimental status of the article and are therefore misleading. Further, the use of this extract is advised not only in functional amenorrhea and the ordinary reflex consequences of physiologic or artificial menopause, but also in conditions where the expectation of benefit cannot possibly be fulfilled (*Jour. A. M. A.*, April 7, 1917, p. 1056).

HEXAMETHYLENAMIN IN PYELITIS.—I. Smith and R. A. Hatcher find that in toxic



doses stovaine produces death in animals by inducing immediate and simultaneous paralysis of the heart and the respiration, the action on each being independent of the other. They find that stovaine disappears rapidly from the blood stream after its intravenous injection. Stovaine is slightly more toxic than novocaine by similar modes of administration and complete recovery does not follow the administration of toxic doses of stovaine so promptly as it does with corresponding doses of novocaine (*Jour. Pharm. and Exp. Thera.*, Jan. 1917, p. 231).

**PARAFFIN FILMS.**—The popular propaganda for "Ambrine" having brought the paraffin film treatment of burns into prominence, Torald Sollmann has instituted experiments to devise a suitable open formula preparation which is simple and yet meets all requirements. He suggests that surgeons who desire to experiment with the paraffin treatment of burns use simple preparations of known composition. Ordinary paraffin melting at about 50 C. (122 F.) appears to possess practically the mechanical properties of "Ambrine." A mixture containing some asphaltum (asphalt varnish, Trinidad or Bermudez, "asphalt cement" and Texas asphalt were tried) gives a preparation of superior pliability. Other formulas are given and their trial suggested (*Jour. A. M. A.*, April 7, 1917, p. 1037).

**PIPERAZIN AND OTHER ORGANIC URATE SOLVENTS.**—From a review of the literature P. J. Hanzlik concludes: There is no reliable evidence to show that piperazin, in small or therapeutic doses, imparts to urine urate solvent qualities, either by direct addition or after excretion; excessive doses produce a slight but negligible increase in uric-acid excretion, the same being effectively produced by sodium bicarbonate or sodium citrate; there is no reliable evidence to indicate that piperazin can remove or prevent urate deposits; diuresis is uninfluenced by even large doses of piperazin and its administration does not materially reduce the acidity of the urine; scientific evidence,

though limited, and clinical opinion indicates that piperazin is valueless in gout. Hanzlik also reports that there is sufficient evidence to indicate the worthlessness of the following as urate solvents; quinic acid, quinoline, colchicum, piperidin, Urosin, Lycetol, Sidonal, Lysidin and Urol (*Jour. Lab. and Clin. Med.*, Feb., 1917, p. 308).

**STERLING VIOLET RAY GENERATOR.**—This is a small frequency apparatus with some vacuum and possibly other electrodes. The apparatus is not one for producing violet or ultra-violet rays in the scientific meaning of those words. The apparatus will not do the things claimed for it in the advertising booklet which includes the treatment of practically every ailment known to mankind (*Jour. A. M. A.*, April 14, 1917, p. 1141).

**THE J. B. L. CASCADE TREATMENT.**—The "treatment" is exploited by Charles A. Tyrrell, New York City. It consists in the self-administration of rectal anemas by means of a device, the J. B. L. ("Joy-Beauty-Life") Cascade. The "complete treatment" includes a stick of Tyrrell's "famous Rectal Soap" and a box of the "Celebrated J. B. L. Antiseptic Tonic." The "tonic" was analyzed in the A. M. A. Chemical Laboratory and found to be a mixture of sodium chloride and impure borax, colored and perfumed. The laboratory concluded that a preparation having all the "antiseptic" and "tonic" properties of J. B. L. Antiseptic Tonic can be made by mixing 2.8 ounces common salt with 1.3 ounce powdered borax. (*Jour. A. M. A.*, Jan. 6, 1917, p. 50.)

**UNNA'S PASTE FOR VARICOSE VEINS.**—In the treatment of varicose ulcers of a mild form Dr. Ochsner prepared a boot composed of several layers of a bandage, each treated with Unna's paste applied hot. The paste consists of gelatine 4 parts dissolved in 10 parts hot water to which 10 parts glycerin and 4 parts zinc oxide are added. (*Jour. A. M. A.*, Nov. 25, 1916, p. 1617.)

## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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**Next Meeting — Tampa — May, 1918**

## THE DUTY OF THE MEDICAL PROFESSION IN THIS WAR.

This is the most destructive war the world has ever experienced. Indeed, it is more than a war. It is a cataclysm in the progress of civilization. In its effects on man it is comparable to the great geologic epochs which have endangered the existence of the race and profoundly modified the development of civilization. Whatever may be the results of this titanic struggle, the trend of man's evolution must be profoundly altered. Ultimately, it may result in benefit to the race; or it may lead to deterioration. Our success, with that of our allies, is essential to the welfare of the world. Defeat would mean not only disaster to ourselves, but the retrogression of all nations. We are fighting to protect our nation against a ruthless aggressor; to aid England, France and Italy, whose ideals are in harmony with our own and who up to the present have been fighting our battles; to restore desolated and ravished Belgium and Serbia; to assist Russia in her struggle for liberty, and to give freedom to the great masses of the German people themselves. The cry for help that comes to us from our allies should cause us to respond with our greatest effort, directed by our highest intelligence, and stimulated by our most unselfish desires.

In this great struggle the medical profession has a part to play second to that of no other group of men. The medical profession has had its peculiar duties and obligations in all wars, but especially in this war. The medical service is the branch of the army whose functions are concerned almost solely with the amelioration of the horrors of war. Our European confreres have shown themselves worthy by their ready enlistments, by their high skill and intelligence and by their altruistic devotion. The high rate of medical corps fatalities testifies to this. Practically every physician in France is in the army, either with the combatants or on detail to take care of

civilians; but in either case he is absolutely at the command of the military authorities. There are today practically no private practitioners in France. Every medical man is subject to order, and is working not in his own interest, but in the service of the State. In England the profession has been so reduced that at present there is only one practitioner for every 4,000 population in densely-peopled districts, and one to 2,500 in the more sparsely-occupied areas, and even these are now subject to call.<sup>1</sup> There the organized profession itself has sole charge of supplying the army with medical officers. This has been, and is still, being done without the necessity of a draft among physicians, except the draft which is exercised by the profession itself. Let there be no slackers among us!

Let there be no slackers! But, also, let there be none to offer themselves, provisionally, asking that they be favored in this, that or the other way. In promoting to higher ranks, the Surgeon General undoubtedly will avail himself of the best information concerning each man's fitness, and in assignment to duty the same care will be exercised. An internist will not be assigned to operative work, nor will a sanitarian be expected to take the place of an ophthalmologist. Individual preference and special fitness, we may rest assured, will receive full consideration in all cases. But it must be remembered that the exigencies of the situation may demand, at times, that the medical officer sacrifice his personal and professional pride and do a service which he may consider a drudgery. This sacrifice he should be willing to make for his profession's honor and for his country's good.

A few prominent men have expressed great disinclination to be assigned to the physical examination of recruits. Yet no more important function falls to the lot of the medical officer than this work. Every

physically unfit man in the enlisted ranks is not only a dead weight to be carried for the present, but also a potential burden on the pension lists to be borne in the future. So far as possible, the final examination of enlisted men in the concentration camps will be made not by individual medical officers, but by boards of experts. On these boards there should be men skilled in the recognition of surgical, circulatory, genito-urinary, dermatologic, pulmonary, neurologic, ophthalmologic and otologic defects. If an army of 1,000,000 men is to be assembled, two or three times this number may need to be examined. These examinations must be carefully, scientifically and conscientiously made. No greater honor and no greater responsibility can come to a medical man, eminent in any of the specialties, than to be placed on such a board. No such opportunity—rich in material from among our diversified population, important to the success of our cause, valuable from a scientific point of view, worthy of the high skill of the specialist—is likely to come again to the medical profession.

The war in Europe has wrought great havoc; it has destroyed millions of lives, has maimed and crippled many men, has littered the fields with shells of destruction, dismantled cities, and crumbled into dust some of the most stately edifices, both secular and religious, ever conceived in the brain of man or reared by his hands. Civilization is not to be lost, and the upward progress of the race is not to be permanently arrested. The potent saving factor in this great catastrophe is scientific medicine. Had disease followed these great armies in like proportion as it accompanied smaller armies in the past, the better part of civilization might have been lost. But in all the belligerent countries medical science has stayed the pestilence and coped successfully with typhoid, typhus, plague, cholera and other infections which in the past often wrought greater havoc than war and determined the fate of nations. The obligation has come to

<sup>1</sup>Draft of Physicians in England, *The Journal A. M. A.*, May 19, 1917, p. 1483; *Compulsory Mobilization of the English Medical Profession*, p. 1486.



us. Let us lay aside our individual interests, forget our personal desires and professional ambitions, and with one accord proceed in the execution of the duty that lies before us.—*Journal American Medical Association*,

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### IMMEDIATE DUTIES OF MEDICAL RESERVE OFFICERS.

Regularly commissioned Medical Reserve Officers, as well as those who are applying, or who are thinking of applying, for such commission are inquiring as to when they will be put on active duty and what that duty will be. Many letters are received in which the writers express the desire to be ready when the call comes, but do not want to make definite arrangements regarding their practice until they know how soon they may have to respond to the call of duty. It is impossible even for the government officials to give the information positively as regards any particular individual. The following is a general statement that may be a basis from which each one may draw his own conclusions: It is probable that many Reserve Corps Officers—those of rather mature age—will be put on active duty to examine recruits. When the examination of these 500,000 recruits actually begins, it will put to the test the “preparedness” of the medical profession. To make a physical examination of 500,000, to give the series of prophylactic injections for typhoid fever and, in the majority of recruits, vaccinate against smallpox, will be an extensive and a serious undertaking. But it probably will be found that nearer 700,000 will have to be examined before the 500,000 “fit” men are secured. Hence we repeat again, the big, immediate work before those of our profession who have volunteered is that of examining recruits. Another point to be considered is this: As they pass their physical examination the recruits will be mobilized in camps to be located in various parts of the

country. Some eighteen camps, it is stated, are being selected. To supply these camps will require 3,500 medical officers—that is, seven medical officers for each 1,000 men. These officers, since they have been drawn from civilian life, will have to meet conditions and problems and perform duties entirely different from those to which they have been accustomed—so different that special training and special instruction are positively necessary. Hence these 3,500 men must go through a course of training. Preliminary details for this training, we understand, are now being worked out. There will be three training camps for medical officers, Fort Oglethorpe, Fort Benjamin Harrison and Fort Riley, each to accommodate 600 men. In addition, smaller groups of medical men will be assigned to, and take their training where reserve officers of the line are taking their special training. As a matter of fact, already quite a number of medical men have been assigned to training camps. Of course the Reserve Officers when trained will be transferred, part to the mobilization camps, and part to assist in the examination of recruits. The men assigned to these camps for training will probably be the younger men—those under 45.—*Journal American Medical Association*.

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### OUR HONOR ROLL

THE JOURNAL publishes below a list of Florida physicians who have been called into active duty as members of the Medical Officers' Reserve Corps, U. S. Army, of the Navy and of the National Guard of Florida. THE JOURNAL hereafter will publish each month additional lists of members of the Florida medical profession called to the colors. It is not feasible to publish the movements of the individual officer, but in all instances mail addressed either in care of the Surgeon General of the Army or the Surgeon General of the Navy, Washington,

D. C., as the case may be, will reach the addressee.

**MEDICAL OFFICERS  
RESERVE CORPS, U. S. ARMY**

	<i>Home Address</i>
Captain Andrew R. Bond . . . . .	Tampa, Fla.
Captain Henry Hanson . . . . .	Jacksonville, Fla.
Captain Graham E. Henson . . . . .	Jacksonville, Fla.
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Captain Harry Peyton . . . . .	Jacksonville, Fla.
Captain Harry F. Watt . . . . .	Ocala, Fla.
1st Lieut. John E. Boyd . . . . .	Jacksonville, Fla.
1st Lieut. T. Z. Cason . . . . .	Jacksonville, Fla.
1st Lieut. T. G. Croft . . . . .	Jacksonville, Fla.
1st Lieut. James S. Davidson . . . . .	Clearwater, Fla.
1st Lieut. Lester J. Efrd . . . . .	Tampa, Fla.
1st Lieut. William T. Elmore . . . . .	Gainesville, Fla.
1st Lieut. Orion O. Feaster . . . . .	Mulberry, Fla.
1st Lieut. Robert F. Godard . . . . .	Quincy, Fla.
1st Lieut. Maurice E. Heck . . . . .	St. Augustine, Fla.
1st Lieut. Frank P. Hixon . . . . .	Pensacola, Fla.
1st Lieut. Roy Howe . . . . .	Daytona, Fla.
1st Lieut. Charles L. Jennings . . . . .	Jacksonville, Fla.
1st Lieut. Richard Leffers . . . . .	Lakeland, Fla.
1st Lieut. John W. McClane . . . . .	St. Petersburg, Fla.
1st Lieut. William G. McKay . . . . .	Jacksonville, Fla.
1st Lieut. Joseph A. Mixon . . . . .	Pensacola, Fla.
1st Lieut. James B. Parramore . . . . .	Jacksonville, Fla.
1st Lieut. Archie R. Parrott . . . . .	Jacksonville, Fla.
1st Lieut. G. C. Tillman . . . . .	Gainesville, Fla.

**THE NAVY**

Passed Asst. Surgeon W. P. Dey . . . . .  
 . . . . . Jacksonville, Fla.  
 Asst. Surgeon T. S. Field, Jacksonville, Fla.  
 Asst. Surgeon J. K. Simpson . . . . .  
 . . . . . Jacksonville, Fla.

**NATIONAL GUARD OF FLORIDA**

Major R. C. Turck . . . . . Jacksonville, Fla.  
 1st Lieut. James B. Griffin . . . . .  
 . . . . . St. Augustine, Fla.  
 1st Lieut. Lucien B. Mitchell . . . . . Tampa, Fla.

**CHILDREN IN WAR TIME.**

*Child Labor on English Farms.*

The various propositions which are now being made for the use of children in farm work lend interest to the English experience with farm labor of children. England is putting her all into this war, and if she has found, in spite of the increasing strain of the passing months, that children's welfare has been needlessly sacrificed, surely the testimony of her officials is timely and important for us.

England has been granting special exemptions from school attendance. Between the outbreak of the war and the first of May last year, 28,000 children of school age had been excused from school for farm work. What do the English official records show about the need for these children's help and the effect upon them of their employment?

The granting or withholding of exemptions has been in the hands of the local education authorities and their policy has not been uniform. Many of them in all sections of the country have consistently refused to excuse children from school. The farmers of these districts have clamored as loudly as others for child helpers, but it appears from available reports that they have managed without the children when the school authorities stood firm.

The Board of Education, during the first year of the war, advised the local authorities as follows: Exemptions should be granted only to individual children after personal investigation of each case; no general breakdown of the laws in any district was intended; the employment of children of school age should be regarded as an exceptional measure and should be allowed only where the authorities were satisfied that no other labor was available. The authorities were to ascertain that application had been made to the labor exchanges with an offer of adequate wages. In no case were the authorities to excuse children if older children past the age of compulsory attendance

were available; the authorities should secure particulars of the work, the wages offered, and the period for which the labor was required; the work should be light and suited to the capacity of the child.

A year later the Board of Education urged a stiffening of these conditions. They laid special emphasis on the fact that the urgency of the need for the child's help might be tested by the amount of wages offered; also, they said, a register should be kept of children exempted, and exemptions should be reviewed at least once in three months to ascertain that the conditions under which they were granted still existed.

In spite of this, the latest report of the Chief Medical Officer of the Board of Education says: "The Board have already expressed their concern to local education authorities at the large number of exemptions which have been granted far too freely and without sufficiently careful ascertainment that the conditions of exemption prescribed by the Government were fulfilled."

The British Board of Trade speaks of various other ways in which the shortage of men for farm labor has been met. Older children have been employed. Women have volunteered for farm work. Machinery has been increasingly used.

*The Labour Gazette* refers also to the low wages offered by the farmers. And in the Parliamentary debates on child labor in agriculture the farmer's liking for a boy who will work for six pence a day is given by some members as an important reason for the demand for child labor. Unofficially it is stated that in those parts of the country where rural wages are highest the least use has been made of children.

That the best interests of the children themselves have been sacrificed is recognized. As the Chief Medical Officer of the Board of Education puts it in his last report: "To withdraw the child from school at an earlier age than that contemplated by the attendance by-laws is to arrest his education on the threshold of the years when he

is probably just commencing to assimilate and consolidate the instruction he has received and is receiving at school. His introduction to labor at this time renders him liable to conditions of strain detrimental to his physical well-being."

A fuller statement of the English situation with quotations from the English reports can be secured from the Children's Bureau, U. S. Department of Labor, Washington, D. C., upon application.

### *Child Labor in Warring Countries.*

"The experience of war time has only demonstrated the necessity—technical, economic, and even physiological—of the labor laws enacted before the war. In our legislation secured in time of peace we shall find the conditions for a better and more intense production during the war."

These words of M. Albert Thomas, the French Minister of Munitions, illustrate perfectly the official attitude of both France and England after two years of emergency exemptions for war industries, according to the Children's Bureau of the U. S. Department of Labor, which has just completed a brief review of all available reports on child labor in the warring countries.

In France and England, earlier standards of hours are being restored, not only to protect the health of the workers but for the sheer sake of industrial efficiency, present and future. In Italy, the Central Committee on Industrial Mobilization has taken steps in the same direction. In Russia, a year before the revolution, a movement was under way to raise the age limit for children in industry.

Canada, Australia and New Zealand, in spite of the great armies of men they have sent to the front, have maintained their labor standards with little or no variation. Victoria has slightly increased the amount of overtime which may be permitted to women and children in special cases. On the other hand, Manitoba has reduced its



legal overtime. No change whatever in restrictions on woman and child labor is reported from New Zealand.

The Children's Bureau sums up as follows the child-labor situation in France and England:

"France, after almost two years of war-time exemptions by which children under 18 were allowed to work at night in special cases, restored the night-work prohibition for girls under 18 and provided that other night workers should be subject to medical supervision. The reason for this is indicated not only in the statement by M. Thomas, quoted above, but again in the following extract from the French official Bulletin des Usines de Guerre for July 31, 1916:

" 'With the continuance of the war it becomes necessary not only to find the best possible disposition of the forces available for our war industries but also to avoid every cause for exhaustion or weakening of the labor employed in our factories. There is a close relation between the conditions in which we place our workers and the improvement or the increase of our war products. For the very sake of the national defense we must conserve all their physical strength for the workers who are responsible for the manufacture of arms and for the output of our factories.'

"France has now under consideration an education bill which would in effect raise the standard of labor protection in war time. It was introduced in the Chamber of Deputies in March by M. Viviani and closely resembles a bill passed by the French Senate in June, 1916. This proposal to establish a system of continuation schools and to require part-time school attendance during working hours by all working children under 17 years of age has the endorsement of the Minister of Commerce and of business interests in all parts of the country.

"A similar advance has been recommended in England by the Departmental Committee on Education for Juvenile Employment after the War. This committee

also advises an effective 14-year age limit for required school attendance without the exemptions permitted by the present law. Supplementary estimates for educational purposes have been presented to Parliament by the Government which look toward a strengthening of adolescent education along the lines suggested by the committee.

"In England as early as 1915 some employers returned to regular labor standards. The British Chief Inspector of Factories and Workshops writes in May, 1916:

" 'The tendency grew as the year passed to substitute a system of shifts for the long day followed by overtime, and this is particularly reported of munition factories in the Midlands and in Sheffield \* \* \* The number of days on which overtime was actually worked tended in many factories to decrease as experience grew of accumulating fatigue and lessened output. Probably for similar reasons Sunday labor also has tended latterly to decrease.'

"The reports of the British Official Committee on the Health of Munition Workers on the waste involved in the long hours worked during the war are well known. They urge the restoring of restrictions and are full of such statements as the following:

" 'Even during the urgent claims of a war the problem must always be to obtain the maximum output from the individual worker which is compatible with the maintenance of his health. In war time the workmen will be willing, as they are showing in so many directions, to forego comfort and to work nearer to the margin of accumulating fatigue than in times of peace, but the country can not afford the extravagance of paying for work done during incapacity from fatigue just because so many hours are spent upon it, or the further extravagance of urging armies of workers towards relative incapacity by neglect of physiological law.

" 'Conditions of work are accepted without question and without complaint which, immediately detrimental to output, would, if continued, be ultimately disastrous to

health. It is for the nation to safeguard the devotion of its workers by its foresight and watchfulness lest irreparable harm be done to body and mind both in this generation and the next.

"Very young girls show almost immediate symptoms of lassitude, exhaustion and impaired vitality under the influence of employment at night. A very similar impression was made by the appearance of large numbers of young boys who had been working at munitions for a long time on alternate night and day shifts."

"In England the war exemptions to the factory laws have not included a lowering of the age limits for factory work. And the exemptions to the school-attendance laws permitted for agriculture and 'light employment' are now bitterly regretted by the general education authority which has sanctioned them."

A fuller memorandum on child labor in warring countries will be supplied by the Children's Bureau, Washington, D. C., upon request.

---

### URGE CHEMISTS TO ANALYZE EACH CITY'S GARBAGE.

"Have your city food chemist analyze your city garbage from week to week and publish prominently what he finds as an index of food saving or waste in your community," is the suggestion the U. S. Department of Agriculture is making to municipal authorities throughout the country. Where there is no official chemist, the Department points out, local chemists capable of determining percentages of fats, protein, starch and organic matter wasted in garbage can render great service to the nation by volunteering to make these analyses in their localities.

Vast amounts of bread, meat and edible fats are wasted in garbage and tons of valuable feedstuff for animals are lost to the food supply of the nation by usual garbage reduction or disposal methods. One

of the first results from the careful analysis of city garbage should be the passage of more rigid enforcement of garbage-collection ordinances, requiring that no glass, tin, wood, burnt matches, paper, string or inorganic trash be mixed with the vegetable material, meat scraps or bones which can be used for feed.

This dual collection of garbage and trash is being rigidly enforced by Germany in all cities of 40,000 people. Garbage so collected from a population of 17,000,000 people in Germany, although the German garbage pail always has been far leaner than the American one and is especially light at this period, furnished briquettes rich in protein which when fed to dairy cattle produced 1,500,000 to 2,000,000 quarts of milk daily.

In most American cities, however, garbage is sent to reduction plants where all the fat and oil it contains is recovered for use in making soap or greases.

The residue after the oil is extracted is used as fertilizer or dumped into the ocean. This practice has been highly profitable because the American garbage pail is very rich in fat, American garbage averaging 3 per cent of fat, while German garbage rarely shows even 1 per cent of fat, as the German people never have been wasteful of animal or other fats. Another reason for the use of the reduction method is that in many cities ordinances prevent the use of garbage for feeding animals, particularly dairy cows, although there is no valid hygienic objection to the use of dried and properly sterilized garbage as food for cattle or hogs.

The Department specialists believe that as the thrift idea gains ground less and less fat will be thrown into the garbage pail and are hopeful that the time is not far distant when the amount of fat will make reduction for the recovery of oils hardly worth while. This will mean that a lot of excellent and valuable foodstuff now being wasted as food will never get into the garbage pail. Even when all fat is eliminated, however, and waste of



bread and cereals and meat has been reduced to a minimum, the garbage pail nevertheless will contain in the form of parings, plate scraps and trimmings a vast amount of material which should be conserved and used as feed for hogs, cattle or poultry. First, however, the people must face the facts and know the truth of their waste, and in bringing this waste home local chemists can render effective service.

### IMPORTANT MEDICAL POSITION.

#### CHIEF MEDICAL EXAMINER OF NEW YORK CITY.

The Municipal Civil Service Commission of New York City announces an examination for Chief Medical Examiner, for which applications will be open in a week or two. Full particulars and applications may be obtained at Room 1400 Municipal Building. The examination is open to all citizens of the United States, but persons accepting appointment must thereafter reside in the State of New York. The compensation proposed is \$7,500 annually for full-time service, and candidates must be at least 30 years of age before the closing date for the receipt of applications.

The incumbent of this position will be in charge of the office of the Chief Medical Examiner of the City of New York, and will perform the duties heretofore performed by the coroners of the various boroughs. Candidates must have a degree from an approved institution, and present evidence of having done, in an official connection, at least *ten* years' work in the pathological laboratory of a recognized medical school, hospital, asylum or public morgue, or in other corresponding official capacity. They must have performed at least 1,000 autopsies. Special consideration will be given to administrative experience, preparation and presentation of evidence in court, and definite published contributions to the science of legal medicine. Copies of such publications should be submitted with the application.

The examination will consist of a practical test with a weight of 3, 75 per cent required; an experience statement with a weight of 4, 70 per cent required, and an oral test with a weight of 3, 70 per cent required. In the practical test, candidates will be required to perform an autopsy and to report in writing on their findings. Candidates will appear before an examining board for the oral test as to their personal qualifications and fitness for the position including a thorough cross-examination.

This position is one of the most important in civil service in the medical and legal lines and the substantial salary and splendid opportunities offered should attract candidates of high standing in the medical profession.

### ALACHUA COUNTY.

WHEREAS, We have learned with deep regret of the untimely death of our co-worker, Dr. E. Lartigue, whose fellowship in our Society was highly appreciated,

*Resolved*, That we are deeply grieved at the death of this valued member of our Society, and hereby extend to his grief-stricken widow and family our sympathy and condolence;

*Resolved*, That these resolutions be furnished his widow and the *Daily Sun*, and inscribed on our minutes as a permanent tribute to his memory.

J. H. HODGES, M. D.,

J. H. COLSON,

E. T. KEGEL, *Secretary*. *Committee.*

WHEREAS, It has pleased the Ruler of the Universe, in his infinite wisdom, to remove from our midst our worthy and talented brother, Dr. J. F. McKinstry, Jr., a distinguished and valued member of this Society,

*Resolved*, That we miss his wise counsels and deeply mourn his loss, and desire to extend to his bereaved family our heartfelt sympathy and condolence;

*Resolved*, That a copy of these resolutions be sent to his grief-stricken widow, a copy furnished the *Daily Sun*, and a copy spread upon the minutes of the Society as a permanent record.

J. H. HODGES, M. D.,

J. H. COLSON,

E. T. KEGEL, *Secretary*. *Committee.*

## BRADFORD COUNTY.

The following resolution was adopted at the last meeting, June 5, 1917, of the B. C. M. S.:

WHEREAS, We are now at war with an enemy country and a persistent call continues to come for physicians to volunteer their services for the medical department of the army and navy, and

WHEREAS, The pay for medical service in the army and navy is in nowise equal to that we receive in civil practice, and

WHEREAS, The personal relation between physicians and their patients is so close that an indefinite service for his country might deprive the patriotic doctor of not only his usual income but his practice as well, therefore be it

*Resolved*, That every physician who is called to the colors in Bradford County, Florida, shall receive from his colleagues who do his practice at home one-third of all the gross collections, to be paid to the physician or his family, monthly, as long as he holds a commission under that of major and no longer. When he returns, irrespective of his rank, his practice shall be returned to him intact.

Any patient consulting a physician who is not one of that doctor's regular patients, is to be asked to state if one of the physicians in the Government service is his regular physician, making it clear to the patient why he is asked that question.

A. H. FREEMAN,  
J. O. PHILIPS,  
J. E. MAINES,

*Committee.*

NEW AND NONOFFICIAL  
REMEDIES.

ACETYLSALICYLIC ACID-SQUIBB.—A non-proprietary brand of acetylsalicylic acid complying with the standards of New and Nonofficial Remedies. E. R. Squibb and Sons, New York City.

AMPULES IRON CACODYLATE-MULFORD, 0.03 GM.—Each ampule contains ferric cacodylate 0.03 gm. in 1 cc. solution. The H. K. Mulford Co., Philadelphia.

AMPOULES IRON CACODYLATE-SQUIBB, 0.03 GM.—Each ampule contains ferric cacodylate 0.03 gm. in 1 cc. solution. E. R.

Squibb and Sons, New York City (*Jour. A. M. A.*, April 7, 1917, p. 1043).

ASPIRIN, L. & F.—A non-proprietary brand of acetylsalicylic acid complying with the standards of New and Nonofficial Remedies. Lehn & Fink, New York City (*Jour. A. M. A.*, April 28, 1917, p. 1261).

DIARSENOL. — A proprietary brand of arsenphenolamine hydrochloride, chemically identical with salvarsan. For a discussion of the action, uses, chemical and physical properties see New and Nonofficial Remedies, 1917, under salvarsan. Diarsenol is marketed in hermetically sealed ampules containing, respectively, 0.1 gm., 0.2 gm., 0.3 gm., 0.4 gm., 0.5 gm., 0.6 gm., 1.0 gm., 2.0 gm. and 3.0 gm. diarsenol. The Council accepted diarsenol for New and Nonofficial Remedies as the available supply of salvarsan appeared to be insufficient to supply the demand, and this preparation conforms to the rules of the Council for acceptance of proprietary preparations. Diarsenol is made in Canada by the Synthetic Drug Company under a license issued by the Commissioner of Patents of Canada. The Farbwerke-Hoechst Company, however, announces that the sale of brands of arsenphenolamine hydrochloride other than that sold as salvarsan is, in its opinion, an infringement of its rights. The company states that all violations of these rights will be prosecuted under the law. (*Jour. A. M. A.*, May 12, 1917, p. 1407.)

FERRIC CACODYLATE; IRON CACODYLATE. —A ferric salt of cacodylic acid containing from 39.7 to 44.9 per cent. arsenic (As). A grayish-brown powder, soluble in water. The use of ferric cacodylate has been proposed in cases where the effects of iron salts and the mild arsenic effect of cacodylates is desired. Dosage: From 0.015 to 0.1 gm.

OPTOCHIN.—ETHYL-HIDROCUPREINE. — A synthetic alkaloid closely related to quinine. It has the antimalarial and anesthetic action of quinine, but toxic symptoms, such as tinnitus, deafness, amblyopia or amaurosis (retinitis) are more liable to occur than

with quinine. Investigations indicate that the drug may be of value in the treatment of lobar pneumonia, when its safe dosage has been determined. Reports indicate that the drug is of decided value in the treatment of pneumococcic infection of the eye (*ulcus corneæ sepens*). Optochin is insoluble in water, but may be used in 1 to 2 per cent solution in a bland fatty oil or as an ointment. Merck & Co., New York.

**OPTOCHIN HYDROCHLORIDE.** — **ETHYL-HYDROCUPREINE HYDROCHLORIDE.** — The hydrochloride of optochin (see above). It has the therapeutic properties of optochin, but is soluble in water. For application to the eye and instillation into the conjunctival sac a freshly prepared 1 to 2 per cent solution in water is used. Merck & Co., New York. (*Jour. A. M. A.*, March 3, 1917, p. 713.)

**PARRESINE.**— A mixture composed of paraffin 94 to 96 per cent, gum elemi 0.20 to 0.25 per cent, Japan wax 0.40 to 0.50 per cent, asphalt 0.20 to 0.25 per cent, and eucalyptol 2 per cent. Parresine acts mechanically. It is used in the treatment of burns, "frostbite," chilblains" and for covering denuded surfaces. For use parresine is melted and applied while liquid by means of an atomizer or brush. The Abbott Laboratories, Chicago. (*Jour. A. M. A.*, May 12, 1917, p. 1406.)

**SIOMINE.** — Hexamethylenamine tetraiodide, containing 78.5 per cent iodine. Siomine is decomposed in the intestine with formation of hexamethylenamine and iodid. It produces the effects of ordinary iodides, from which it differs only in that, being insoluble in water, it may be administered in solid form. It is marketed in the form of Siomine Capsules containing, respectively,  $\frac{1}{4}$ ,  $\frac{1}{2}$ , 1, 2 and 5 grains of siomine. Howard Holt Co., Cedar Rapids, Iowa. (*Jour. A. M. A.*, May 12, 1917, p. 1406.)

**SOFOS.**—A mixture of sodium dihydrogen phosphate and sodium hydrogen carbonate rendered stable by coating the particles of one of the constituents with disodium hydro-

gen phosphate. One part of sofos has the same phosphate value as 1.75 parts sodium phosphate U. S. P. When sofos is treated with water, sodium phosphate ( $\text{Na}_2\text{HPO}_4$ ) is formed and carbon dioxide is set free. Sofos has the physiologic action of sodium phosphate. It is claimed to have an advantage over the effervescent sodium phosphate preparations in that it is free from citrate or tartrate. The General Chemical Co., New York City. (*Jour. A. M. A.*, May 26, 1917, p. 1551.)

**STERILE AMPULES OF MERCURY SALICYLATE, 1½ GR.**—1 c. c. of suspension containing 1½ grains mercuric salicylate in a fatty vehicle solid at ordinary temperature. Each ampule contains more than 1 c. c.

**STERILE AMPULES OF MERCURY SALICYLATE, 2 GR.**—Each 1 c. c. of suspension contains 2 grains of mercuric salicylate in a fatty vehicle solid at ordinary temperature. Each ampule contains more than 1 c. c. of suspension. Hynson, Westcott and Dunning, Baltimore, Md. (*Jour. A. M. A.*, May 12, 1917, p. 1407.)

**TABLETS SODIUM CHLORIDE AND CITRATE-SQUIBB** (Dr. Martin H. Fischer).—Each tablet contains sodium chloride 1 gm. and sodium citrate 2 gm. E. R. Squibb & Sons, New York.

**TABELLAE DULCES ARISTOCHIN** (WESTERN), 1 GR.—Each tablet contains aristochin 1 gr., with cocoa, sugar and saccharine as vehicles.

**TABELLAE DULCES HEROIN** (WESTERN), 1/100 GR.—Each tablet contains heroin 1/100 gr., with cocoa, sugar and saccharine as vehicles.

**TABELLAE DULCES NOVASPIRIN** (WESTERN),  $\frac{1}{4}$  GR.—Each tablet contains novaspirin  $\frac{1}{4}$  gr., with sugar, starch, liquid petrolatum, saccharine, curcuma and oil of lemon as vehicles.

**TABELLAE DULCES TANNALBIN** (WESTERN), 1 GR.—Each tablet contains tannalbin 1 gr., with cocoa, sugar and saccharine as vehicles.

**TABELLAE DULCES TERPIN HYDRATE**



WITH HEROIN (WESTERN), 1/100 GR.—Each tablet contains terpin hydrate  $\frac{1}{2}$  gr., and heroin 1/100 gr., with cocoa, sugar and saccharine as vehicles. Western Chemical

Company, Hutchinson, Minn. Accepted for the Appendix to New and Nonofficial Remedies. (*Jour. A. M. A.*, Feb. 10, 1917, p. 461.)

## PUBLISHER'S NOTES

### HYPODERMIC MEDICATION.

Hypodermic medication usually means emergency medication. When the occasion for it arrives, the physician, if he is to employ a tablet solution, is fortunate if he has tablets upon which he can depend. The failure of the tablet is his failure—he can not shift the burden of responsibility. And tablets for hypodermic use, to be reliable, must possess a number of important qualifications. They must be true to label; they must be active; they must contain a definite amount of medicament; they must be soluble.

These thoughts were vividly impressed upon the mind of the writer upon the occasion of a recent visit to the hypodermic-tablet department of Parke, Davis & Co. Here we see hypodermic-tablet manufacture reduced to a science. Here we find tablet-making facilities that exist probably nowhere else in the world. The equipment is complete to the last degree. The department is spacious, light, airy, clean. It is supervised by an expert who has specialized for years in this branch of manufacturing pharmacy and who has selected his assistants with discrimination. Every worker is an adept. Every hand is schooled to its task.

In the manufacture of Parke, Davis & Co.'s hypodermic-tablets the components of the various formulas are weighed and reweighed, checked and rechecked by two experienced pharmacists working independently, one acting as a check upon the other, thus guarding against the possibility of error.

firmly established and for thousands of years the oat has been the advocated food.

It contains a higher percentage of albuminoids than any other grain, viz, 12.6—that of wheat flour being 10.8—and less percentage of starch 58.4, as against 66.3 in wheat. It has rather more sugar, viz, 5.4—wheat flour having 4.2—and nearly three times the amount of fat, 5.6, as against 2.0 in flour. Salts amount to 3.0 per cent in oats, but are only 1.7 in wheat.

The rolled oats marketed by The Quaker Oats Company, of Chicago, are worthy of particular note as only selected, plump oats are used, one bushel of grain yielding but ten pounds for the finishing process.

---

### AFLOAT AND ASHORE.

Two new products which are attracting unusual attention, both in this country and abroad, are CHLORAZENE (Abbott), Dakin's New Antiseptic, and PARRESINE (Abbott), the improved, hot-wax dressing for burns. Both of these remedial agents have been passed by the Council of Pharmacy and Chemistry of the American Medical Association, to appear in their "New and Nonofficial Remedies," and have been ordered by the United States Navy to be placed on every ship.

The results which are reported by surgeons and hospitals in the use of CHLORAZENE and PARRESINE are so remarkable that it would surely pay every physician to become better acquainted with these products.

The nutritive value of oatmeal, as compared with that of wheat flour, has been

Literature will be sent on request to The Abbott Laboratories, Chicago, Illinois.



THE JOURNAL  
— OF THE —  
Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV      St. Augustine and Jacksonville, Fla., August, 1917      Yearly Subscription, \$1.00  
No. 2      Single Copy, 15c.

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, August, 1917

Number 2

## ORIGINAL ARTICLES

### VOLKMANN'S CONTRACTURE.\*

J. K. SIMPSON, M. D.,  
Jacksonville, Fla.

The condition which bears the name of Volkmann's contracture is a shortening of the flexor muscles of the forearm, causing a flexion of the fingers with loss of ability to extend them.

It is the end result of a disease of the muscle bellies of the flexor muscles, spoken of as traumatic or ischemic myositis. The condition usually follows an injury near the elbow, fracture or dislocation or both, and was formerly attributed directly to the injury. It is now, however, a well-established fact that the lesion is due to treatment of these injuries rather than to the injuries themselves, and Murphy refers to it as the "surgeon's lesion." The sequence of events leading to the condition of Volkmann's contracture is as follows:

A child between the ages of four and fourteen receives an injury in the region of the elbow usually from a fall. The injury may be a fracture, a dislocation or only a sprain. The elbow is put up in splints, bandages, adhesive plaster, plaster of paris, or in acute flexion. There occurs an acute swelling of the soft tissues from extravasation and edema, a congestion of the veins, a partial occlusion of the arteries, a stagnation of the blood, thrombosis of some of the smaller vessels, and the whole pathologic expansion of the soft tissues is held in a non-expandible case composed internally of the fibrous and bony envelopes of the muscles and externally of the dressing applied by the physician. During this stage of the disease

the child suffers extreme pain, the fingers become rather cyanatic and edematous and later numb and stiff.

This is the stage in which the treatment of Volkmann's contracture is most effective. The apparatus should be removed immediately, not the next day and not two hours later, for the damage may be done in a few hours, and is usually done in the first twenty-four to forty-eight hours. After removing the apparatus the arm should be put in semi-flexion, elevated, given gentle massage and every effort made to lessen the swelling and promote a return of free circulation. As a last resort it is theoretically good practice to split the fascia covering the muscles, either subcutaneously or with the skin, over the whole length of the flexor muscles, to decompress them.

If nothing is done during this stage except to give the child some sedative, as is too frequently the case, the next stage of the pathologic sequence occurs, which is cloudy swelling and death of the individual muscle fibers. Then when the dressings are removed in two or three weeks the child can not flex the fingers, not because of nerve injury, but because of the loss of the contractile power of the muscle, due to death of its fibers. This death may be limited to certain areas or may be complete.

From this stage on, for a period of three or four months, there occurs the last pathologic stage in the sequence; the absorption of the cellular exudate, the replacing of the muscle fibers by connective tissue, and the contraction of the connective tissue, as any scar contracts as it grows older, causing a shortening of the flexor muscles, and a consequent flexion of the fingers. This is exaggerated by growth of the bones, which

\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.





Fig. 1. Note the extreme flexion of the fingers, and how the flexor tendons stand out at the wrist when the wrist is extended. The fingers could be fully extended when the wrist was fully flexed.

serves to lengthen the distance between the origin and insertion of the muscles, now composed of nearly inelastic cords. This brings us to the condition known as Volkmann's contracture, the diagnosis of which is easy, but the treatment unsatisfactory at best.

There may be varying degrees of nerve damage coincident with the damage to the muscles, or even resulting from inclusion of the nerves in the fibrous tissue of the muscles. The ulnar and median nerves are the ones most often affected. Thomas found in a search of the literature including 107 cases that nerve lesions occurred in 62 of the cases.

Treatment in the final stage of the disease has as its aims the correction of the deformity, and the restoration of as much of the contractile power of the muscles as is possible, and the success of the treatment is in direct ratio to the amount of normal muscle tissue remaining in the muscles.

The deformity may be overcome by any one of three methods: (a) Gradual stretching of the shortened muscles by some mechanical appliance. (b) Lengthening the tendons of the affected muscles by a sliding tenoplasty. (c) Shortening the distance between the origin and insertion of the muscles by resecting a section of bone in each of the forearm bones.

There are sound arguments put forward in favor of each of the methods by their advocates, but personally I prefer lengthening the tendons. It is true that in advising any open operation on these cases one has to consider the fact that the tissues, due to poor circulation and trophic changes, may not heal kindly; but against the gradual stretching there is the tendency of stretched fibrous tissue to recontract, and of further



Fig. 2. The hand is here shown put up in the elastic extension apparatus made after the design of Dr. Alfred Taylor of New York for the purpose of extending the shortened joint capsules. The hand splint is made of sheet zinc cut and moulded to fit the extended hand.



damaging a weakened muscle by stretching its fibers. It is a recognized requisite everywhere in treating weakened muscles by physical therapeutics, that the muscle in question be kept relieved from all strain, fatigue and over-stretching. Mechanical correction of the deformity followed by prolonged physical therapeutics has seemed to me to offer the best chance for recovery in these cases.

I wish to submit the record of a case which is still under my observation.

The patient is a boy sixteen years of age, who came under my observation on the 15th of November, 1916.

The family history and past medical history have no bearing on the present trouble. He was always healthy until the present trouble began, and in fact his general health is still good.

He came to me because of the loss of all use of the left hand, due to flexion of the fingers and to a severe hyperesthesia of the skin of the palm.



Fig. 4. Shows the hand in the voluntary act of grasping an object.

The history of the onset is as follows:

February, 1916, he was thrown from a horse and struck the ground on his left arm near the elbow. He was told by a physician that there was a dislocation of the elbow, and a fracture of the arm above the wrist. He was anesthetized and his arm put into a splint and bandaged. The arm immediately began to swell and to give him intense pain, the hand also was badly swollen. The bandage was removed three days after its application. Three weeks after the injury the dressings were removed and an operation performed in the region of the elbow, an incision being made on the anterior surface. He does not know the nature of the operation nor why it was performed. About a week after the operation he began to have various paresthesias of the palmer skin, and that of the palmer surfaces of the fingers. This area then became very hyperesthetic and has remained so to the present time. The wrist and elbow were stiff at first after the splint was removed, but they soon regained the normal amount of motion. The fingers, however, have remained in the



Fig. 3. Shows the amount of voluntary extension of the fingers and also the separation two months after operation.

flexed position, and have grown gradually worse up to two or three months ago, since which time they have remained about the same.

#### *Examination.*

A complete physical examination shows nothing of pathological import other than that found in the hand and forearm, with the exception of enlarged tonsils. The affected arm and hand show the following changes: There is a scar on the anterior aspect of the bend of the elbow, which has widened into a semikeloid formation. There is a general atrophy of the muscles of the forearm, and those of the flexor group show the most marked change. The bellies of these muscles are distinctly smaller than normal, and are hard and brawny to palpation. The bellies do not extend as far down the arm as normal, appearing to be mostly tendinous. There is a decided atrophy of the thenar, hypothenar and lumbricales. The fingers are flexed into almost full flexion, and this is increased upon voluntary or passive extension of the wrist. This is caused by a distinct shortening of the flexor muscles, especially the flexor profundus group, which acts as a bowstring of the wrist.

All motions at the wrist and elbow are normal. There is no complete paralysis of any of the muscle groups, but a decided weakening of the flexors. There is, therefore, no nerve paralysis present. Tests for sensation show that there is nowhere a loss of sensation, and except for the palmer surface of the hand and fingers, especially the middle and forefingers, the sensation is normal. In this area, that of the cutaneous distribution of the median nerve, there is a very decided hyperesthesia, amounting to a real pain when this part of the skin is lightly brushed. The skin of the lower forearm, hand and fingers is somewhat skiny, and the circulation is not good in the hand, which easily becomes cyanotic. Manipulation of the scar at the elbow causes paræsthesia in the distribution of the median

nerve. No neuroma can be felt at the elbow. X-ray examination shows no evidence of present or past bony or joint lesion.

#### *Explanation of Symptoms and Clinical Diagnosis.*

The flexion of the fingers is due to shortening of the flexor muscles, especially the profundus digitorum. This has been caused by a traumatic myositis involving the bellies of these muscles, caused by the application of tight bandages at the time of the injury, and followed by the appearance of scar tissue in the substance of the muscles, replacing the muscle fibers, contracting and causing a shortening of the muscles with impairment of their contractile power. The case is not one of nerve paralysis, as each group of muscles respond to central contraction impulses. The hyperesthesia over the palmer surfaces of the fingers I attribute to the inclusion of the median nerve in the scar at the flexion of the elbow, acting as an irritating lesion.

#### *Treatment.*

On the 11th of November, under a general anæsthetic, the following operation was done. The median nerve was exposed and found to be surrounded by scar tissue, being densely adherent to the skin and underlying tissues. This was dissected free from the scar, surrounded by an egg membrane, and buried in a deeper channel under the muscles.

An incision was then made over the shortened flexor tendons just above the wrist, and each one separately lengthened by a split and sliding tenoplasty, from one to two inches, until the hand could be brought into full extension without pull on the tendons. Due to the contraction of the ligamentous structures on the flexor surfaces of the fingers from the long continued flexed position, it was necessary to gradually stretch them, so the hand, after the wounds had healed with the application of a splint, was put into the present extension apparatus.

I used egg membrane for making a new tunnel for the nerve, and for new tendon

sheaths, for two reasons: First, because there was no fat in the arm which could be utilized for that purpose, and, secondly, because the skin was so tight over the wrist that it would not permit the introduction of much extraneous material and at the same time allow for proper closure. The wounds healed by primary union.

At last report he was using his hand in eating, dressing himself and was able to lift about five pounds in the grip of his hand.

The hypersthesis of the palmer surface of the fingers entirely disappeared after the operation and has not returned, the sensation now being perfectly normal.

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### THE ADVANTAGES OF THE PROPER HANDLING OF ACUTE APPENDICITIS.\*

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Perhaps there is no other situation which taxes to such a degree the judgment and persuasive powers of the surgeon and practitioner, as that of deciding what to do in getting his advice followed after he has made the diagnosis of early appendicitis. Not one of us can predict with certainty what will be the outcome if conservative measures are followed and the disease permitted to take its own course. The practitioner sees many times what may appear in the beginning a severe case of appendicitis, clear up in just a few days, consequently he may hesitate to advise operation as soon as the diagnosis is clear in his mind. To him falls the problem of presenting in the best manner to the patient and his family the question of operation. "What will happen, Doctor, if we wait," is so often asked of him and he is pressed to make a reply what will be to the best interest of the patient. To state simply that the condition

may develop into one of abscess with peritonitis often does not carry with it sufficient definiteness to impress the patient and his family that such a disastrous outcome could follow in their particular case; and we know that it might not. It is our object in presenting this paper to give the experience with appendicitis at the Riverside Hospital during the past five years, in the hope that this experience may be of some service in offering a concrete instance of what happens when the operation is performed early and what happens when it is postponed until drainage has become necessary. We will consider our efforts worth while if this experience should be of help to one who is confronted with the problem of making the family and patient see the importance in not postponing operation when an early diagnosis of appendicitis has been made.

We have selected only those cases of appendicitis which were not complicated by other surgical conditions. We have also studied the cases in which appendectomy was performed for chronic appendicitis in order to make a comparison with those operated upon for acute appendicitis without drainage; and, of course, we report those cases of acute appendicitis which have gone on to abscess and peritonitis. In all there are 90 cases of chronic appendicitis, 101 of acute appendicitis without drainage and 106 of acute appendicitis with drainage. The total number of operations for appendicitis is 489.

We are often asked by the patient how long an operation would necessitate his being in the hospital. To many, this is of great importance, since the matter of expense and time from business may influence one either to decide for or against immediate operation. The average stay in the hospital for those operated upon for chronic appendicitis was  $10\frac{1}{2}$  days and those for acute appendicitis without drainage  $9\frac{1}{2}$  days. This at once suggests to us that it is usually poor judgment to wait until an attack is over in order to do the so-called in-

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\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917



terval operation. We are more forcibly impressed with this when we observe that there are no more complications nor greater mortality in one class than another. Just at this point there also arises the possibility that the attack in consideration may be the one in which the abscess or peritonitis may develop. The average stay in the hospital for those patients where drainage had to be instituted was  $22\frac{1}{2}$  days. Thus we see that if the operation is done before drainage is necessary, the hospital time of the patient is just two and a half times as much as when the disease has progressed to the point where it requires drainage; in other words, the hospital can care for two and a half times as many patients and with the same expense if the operation is done sufficiently early that the wound can be closed.

We are greatly pleased in studying the records to find that with the patients where no drainage was necessary, convalescence was so uneventful. There has not been one case of frank pneumonia. There were only two instances in which abscess developed in the wall after the operation. Even then their hospital time was less than that after the operation for abscess. We have not a complete record of the occurrences of fecal fistula nor can we tell just how long there has been drainage in abscess cases after the patient left the hospital, but to all comes the experience where this has extended over weeks and probably months with the necessity finally of operation for closing the fistula or drainage tract.

In the 195 cases without drainage there has not been a death. The mortality, however, where abscess and peritonitis had developed was 7 per cent, that is 7 cases out of 105. Of these, one also had diabetes mellitus. The deaths occurred at various lengths of time after operation, from one day to several weeks. Further comment is hardly called for since the figures show so plainly the practical safety when the operation is performed early, and the chances we are running by postponing it until the ne-

cessity arises for a drainage operation to be performed.

We beg to digress long enough to refresh in our minds the importance of not using purgation when there is a possibility of inflammation of the appendix. This was impressed upon us very forcibly several months ago when on opening an abdomen there was found free in the peritoneal cavity castor oil which had been given to the patient several hours previously. It is our custom always to postpone catharsis when there is abdominal pain, rigidity and fever. If it is not possible to make a definite diagnosis, the safest course to follow is to stop food, apply an ice bag to the abdomen, give enemata, omit opiates, and watch the symptoms closely until the exact nature of the disease can be determined.

A conclusion for such a short paper would seem amiss, but we wish to restate what we have learned by experience in the surgical handling of acute appendicitis. The early operation, that is, an operation before drainage has become necessary, has the following advantages over a later operation: First, there is great saving in time and expense to the patient; second, convalescence is more comfortable and uneventful; third, complications are reduced to a minimum; fourth, there is practically no mortality. Could these four points be presented to each patient it would be far easier for him to see our point of view and follow those lines of treatment which would assure him the quickest and surest recovery.

It would be helpful to us all to keep in mind the advice of the late John B. Murphy: "The initial symptoms of appendicitis are clean-cut and almost unmistakable. The later symptoms are almost equivocal and not to be relied on. The mode of onset of an attack of appendicitis is no clue to its probable course or complications. We can never tell in a given case what the next day may bring. Therefore, operate today. By operation we may take the course of the disease into our own hands. By not operating we



leave the case in the hands of a blind and often terrible, cruel fate."

## THE INDICATIONS AND ABUSE OF CESAREAN SECTION.\*

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The large increase in the number of Cesarean sections being done during the past few years throughout the country, very properly brings before us the consideration as to whether the frequency of this operation is justified or not, and a statement of its indications and contraindications. The ease and safety with which the peritoneal cavity can be entered, if the rules of modern surgery are followed, has tended to make it quite popular among the profession, and to a certain extent among women.

The short time it takes for its performance, the absence of shock, of lacerations and injuries to the mother's soft parts, no injuries to the babies, make a decided appeal to the obstetrician; while the relief from the suffering of a long and tedious labor appeals more strongly to the woman. Owing to the great amount of sentiment connected with this operation, it pains me to say that this sentiment is unfortunately taken advantage of by some men surgically inclined. They are biased by their knowledge of what can be safely accomplished by surgical means; others who do no surgical work at all, but have attained a certain degree of skill in delivering difficult cases, are prejudiced in favor of Cesarean operations. To my mind the best course to pursue is to weigh the evidence of our findings, and give the mother and baby the benefit of our obstetric surgical judgment.

Therefore, in considering the method of delivery of our prospective mothers, we must consider not only the immediate morbidity and mortality, small as it is, but the

possibility of rupture of the uterine scar under strain. Bearing these dangers in mind, there is a small but definite group of cases which can be delivered more safely by abdominal section than by the natural passage, and in my opinion it is only by adhering closely to the more or less definite indications rather than operating on all possible cases, that we can keep this valuable operation from falling into disrepute.

In looking over recent literature, I find a very large number of conditions given as reasons for operating. Some of these indications I will mention:

Absolutely contracted pelvis, disproportion between fetus and pelvis, contracted pelvis (borderline cases), contracted outlet in funnel pelvis, habitual fetal death in labor, prolapsed cord, tumors obstructing birth canal, stenosis of cervix from scar tissue or cancer, eclampsia, placenta, previa, premature separation of placenta, cardiac decompensation with complications, edema vulva, face, brow, posterior occiput and transverse presentation, breech presentation in primipara and pyelitis.

In this long list there are a very few definite indications, a number of allowable indications, more of very hazy indications, and some that are indefensible. I will take some of the indications up separately.

### *Absolutely Contracted Pelvis:*

About this condition there is little argument. Williams states that "A true conjugate of less than 7.5 c. m. renders spontaneous birth impossible, though it is possible after craniotomy." Personally I could never recommend craniotomy, as I think it the most brutal and not indicated operation in obstetrics.

### *Contracted Pelvis (Borderline cases):*

These would be the cases with a true conjugate above 7.5 c. m., and here the obstetric judgment and individual preference of the attendant comes into play; fortunately, in this country, extreme degree of pelvic contraction with marked deformity are extremely rare. We have, however, a large

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number of relative contractions which may be grouped under this caption:

First—Those with flattening of the inlet, with simple flat pelvis, a result of nutritional disturbance or early occupational deformity.

Second—The justo-minor or generally contracted pelvis. In addition to these brim contractions, which so often pass unnoticed until they cause distocia.

Third—The funnel pelvis or contracted outlet is not without clinical importance.

These three types of pelvis causes a little change in the general appearance of the woman, that unless the practitioner resorts to routine pelvimetry, many women will fall into labor and dystocia result without his appreciation of the cause. The modern obstetric art assumes that the man who undertakes the delivery of a woman is sufficiently equipped to deliver her by such means as will insure a living child and a living mother whose soft parts have not been sufficiently traumatised, or if these have been unduly injured, to repair them in such a way as to leave her anatomically normal. To accomplish this end successfully and give each woman what she is entitled to, she must receive proper prenatal care in order that her general health may be put in the best possible condition to withstand the strain of labor. If she is a multipara, this investigation must also include a history of her previous labors, and an investigation of her inlet and outlet diameters; if she is a primipara, more exact mensuration becomes of still greater importance, because we have no record of past labors to guide us during subsequent performances. Furthermore, it is important to estimate by external palpation and fetometry the approximate size of the fetus, and to accurately determine its presentation, position and posture. No physician should undertake the care of obstetric cases unless he has the time and willingness to study the rate and rhythm of the fetal heart throughout the course of labor, for obstetrics today is knowing what you are going to meet and preparing your-

self to meet it, and in all difficult labors the character of the fetal heart determines the course to be persued. Obstetricians now, more than ever before, are recognizing the right of the unborn child; the heart during a normal contraction of the uterus in the second stage, shows extreme flights, add to this the trauma of moulding, and we get cyanosis, etc. Finally the most important factor in the conduct of a complicated labor is the training in obstetrical technique and asepsis. It is beyond dispute that vaginal examinations made through an unprepared introitus bear a direct relation to the frequency of sepsis. An obstetrician should be able to carry a woman through labor and note the progress of the fetus in its descent through the pelvis by repeated abdominal and rectal examinations.

Granted a man is equipped to do obstetrics, each case resolves itself into the question of whether a particular baby can pass through a particular pelvis at this time. The ability to answer this question is what makes a successful obstetrician, for whether the fetus will or will not pass through a given pelvis depends on the relative size of the fetus and that pelvis, the malleability and mouldability of the fetal head, the presentation, position and posture of the fetus, the axial relation of the fetus to the several planes of the pelvis, and the force of the uterine contraction. It is not difficult for a man to recognize an absolute contraction of the pelvis, which will not permit the passage of any child, but it is difficult for him to estimate the prognosis in a relative disproportion where the child has gone over term with ossification of the fetal vault or where the baby is oversize from overfeeding, or where the inclination of the pelvis does not admit of its ready entrance, or where the brim contraction, though slight, is enough to disturb a normal posture. It is these cases that test the skill of the accoucheur.

In pelvic contraction, with a true conjugate of 8.5 c. m. or more including justo-minor pelvis, each woman should be given

an aseptic test of labor before determining what mode of delivery is necessary. Statistics show that a great percentage of them will be delivered spontaneously. Experience has taught that to say a conjugate vera of 9 c. m. or less demands section without weighing other factors upon which successful delivery depends, or without giving the individual case a test of labor, is not scientific obstetrics and subjects the woman to hazards which she should not be asked to take.

Just a word regarding the induction of premature labor as a method of treatment in pelvic contraction. It is a thing of the past, for it is an abnormal labor and opens the way to sepsis, operative intervention, and is bad judgment; the premature child bears trauma badly. Some obstetricians contend that podalic version and extraction is a solution of the difficulties in minor degrees of flat pelvis; podalic version should be regarded as an emergency obstetrical procedure, and one fraught with a great deal of danger both to mother and child. I am of the opinion that in those cases where, after a test of labor, the head fails to engage pubiotomy or Cesarean section gives the child the best chance.

Surely the maternal results from section are as good as those from the use of forceps on the unengaged head, while there is more or less danger to the child; forceps to the floating head cannot be too strongly condemned, as bruised and maimed babies and death from compression are not of infrequent occurrence, and in addition, the woman's soft parts are extremely damaged. It is poor obstetrics to do a Cesarean section because we have the opportunity, because it is easy and simple, or because we can persuade ourselves or the patient that it is permissible on account of a slightly contracted pelvis. It is also bad obstetrics to drag a child through a small pelvis by forceps or version simply to demonstrate our ability to do so. These borderline cases should be decided by trying to put aside our personal

preference and prejudice and deciding what is for the best interest of mother and baby. If we cannot come to a conclusion, it surely is permissible to allow the test of labor for a limited number of hours, hoping that the head will engage. If we find that the head will not engage, we can operate, and if it does engage we have the satisfaction of not performing an unnecessary operation.

#### *Contracted Outlet:*

The funnel type of pelvis is more common than is generally supposed, and many women who give a history of low forceps belong to this class of type. Fortunately we do not see many of the badly contracted outlets; they may cause trouble in delivery. However, if the distance between the tubera ischii measures less than 8 c. m., the anterior and posterior sagittal should be estimated. If the posterior sagittal falls short, it is better to do Cesarean than to subject the baby to the danger of cerebral hemorrhage from a difficult forceps extraction; as has been pointed out, it is sometimes easy to get a head in a pelvis but difficult to get it out.

#### *Habitual Fetal Death in Labor:*

We should do our best in these cases to determine the cause of the previous deaths, by Wassermann reaction, careful exploration of the pelvis cavity, etc. If we are unable to ascertain the cause and are therefore unable to correct it, I feel that these women are entitled to a Cesarean section to obtain a living child.

#### *Tumors Obstructing Birth Canal:*

Tumors obstructing the birth canal form a more or less indication for section. These may be uterine fibroids or the various solid or semi-solid ovarian tumors; but as they often become gangrenous from labor pressure or torsion of pedicle, it is safer for the mother not to subject her to the risk of labor.

#### *Prolapse of Cord:*

This complication in a multipara should never be an indication for section. In a primipara with rigid cervix it may be an indication.



*Placenta Previa:*

No one would agree that all placenta previa should be treated by section, and surely no one should say that no placenta previa should be so treated. The ordinary classification of placenta previa is that of marginal or only a slight encroachment on the cervix partial or the os partly covered by placental tissue. Complete the os completely covered, central the os not only completely covered but near the center of the placenta. Considering the subject in all its phases, I cannot feel that Cesarean section is to be recommended save in a very few cases of placenta previa. It can never come into general use in the treatment of such cases, because of the multiplicity of inherent dangers, and because placenta previa is always an emergency, and must be treated as such. As soon as the diagnosis is determined, the treatment should begin. There must be very little delay. If there is much hemorrhage, we can't wait until the child is viable. The time lost while repeated hemorrhage occur, repeated examinations are made, and repeated tampons are applied, mean a constantly lowered resistance and almost certain infection for the mother. If the child is viable, the Braxton-Hicks method should be chosen, bringing down a leg to act as a plug that may be pulled down, if necessary, to restrain hemorrhage, pulling on the leg as little as possible, but allowing spontaneous delivery of the shoulders with prompt delivery of the after coming head, offers the child the best chance for life, and it is fairly safe for the mother. If the child is not viable, then all that is necessary is to rupture the membrane freely and await spontaneous delivery.

Cesarean section, if used in central implantation and in some of the complete variety, will give a much lower mortality than if we use other treatment and allow our patient to become exsanguinated during the slower delivery. Whatever treatment is

used, the fetal mortality will always be considerable as many of the infants are premature or weak from loss of blood.

*Premature Separation of Normally Implanted Placenta:*

Most of these we see are not especially serious, and may safely be treated as we would treat a mild degree of placenta previa by dilating the cervix with a hydrotatic bag. Williams reports several cases of a very dangerous type in which the body of the uterus has undergone degeneration and refuses to contract. This type should be kept in mind, and a section should be done followed by a hysterectomy.

*Eclampsia:*

There have been many theories advanced as to the cause of this serious complication of pregnancy, and as many methods of treatment, two of the most rational theories are:

First, an excess of cytotoxin (a proteid poison originating from the fetus), circulating in the maternal blood and which is not neutralized by sufficient cytolytin of maternal origin.

The other theory is that it is an excess of the products of maternal and fetal metabolism which the liver and kidneys can not dispose of. The concensus of opinion is, I think, that the theory of a protein poison is the nearest right; what the real cause is we don't know, except that it is a toxæmia in which the kidneys and liver are the chief organs to sustain damage. Taking for granted that it is a toxæmia caused by the product of pregnancy, to my mind I think the most rational thing to do is to remove the cause and empty the uterus either by a vaginal section or abdominal Cesarean section. We must not lose track of elimination, rectal lavage, morphia, chloral, bromide, etc. I am not going into the treatment of eclampsia by the watchful, waiting policy, which is so popular in the minds of many.



## THE SIGMOID.\*

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In selecting the sigmoid as my theme, I wish to preface my remarks by saying that I have no thought whatever of going into the subject in extensive detail. My plan is to discuss it in a general way and touch a few of the points that appeal to me as I see them in my daily practice.

The sigmoid flexure of the colon, which I shall hereinafter refer to as the "sigmoid," takes its name from the fact of its resemblance to the letter "S." In the textbooks it is described in the following manner under the name of the pelvic colon: It is a large coil of intestine which begins at the inner border of the left psoas muscle, where it is continuous with the iliac colon, and ends at the level of the third sacral vertebra by passing into the rectum proper. Between these two points it has a well developed mesentery and forms a large and variously shaped coil which usually lies in the cavity of the pelvis, most commonly, however, it has the following arrangement: Beginning at the inner margin of the left psoas muscle, it first plunges over the brim into the pelvis, and crosses this cavity from left to right; it next bends backward and then returns along the posterior wall of the pelvis towards the middle line where it turns down and passes into the rectum.

The usual length of the sigmoid is about sixteen or seventeen inches. It may be as short as five or as long as thirty-five inches. In the lower part of the sigmoid the longitudinal layer of muscle is complete with the exception of a narrow part on each side. The sigmoid is covered with peritoneum and is the narrowest portion of the entire colon.

*Function of the Sigmoid.*

The function performed by the sigmoid is of striking and peculiar interest. In the past few months we have learned to look very

much more respectfully upon the office of this small section of bowel than ever before, as we know now that in a very large percentage of gastro-intestinal disturbances and systemic conditions that this formerly much-despised and long-suffering intestinal loop is topographically and pathologically at the bottom of the trouble. It connects the descending colon with the rectum and serves the purpose of a receptacle or collection depot for bowel residue which is about to be discharged from the body. It guards the opening and closing of the tightly folded canal which forms the junction between the sigmoid loop and rectum. As feces are gradually deposited in the sigmoid loop it slowly rises higher and higher until it is filled, at which time the recto-sigmoid junction opens and the feces are pushed on into the rectum. This entire process is wholly automatic and although controlled in a manner illustrating wonderful intelligence, the complete function of this loop is performed without our consciousness. It is obvious that when the sigmoid loop is functioning properly, it not only measures but weighs with considerable accuracy each discharge forced into the rectum. The residue remaining from ingested food should reach the sigmoid in from ten to twelve hours after eating.

*Normal Variations in the Sigmoid.*

Since the advent of radiography and fluoroscopy our attention has been called particularly to the great differences that exist in the sigmoid of different individuals as to size, length and motility. The length of the sigmoid is usually commensurate with the length of the colon and generally speaking the more redundant the sigmoid, the greater is its diameter. It is said of the Russians who eat a great deal of bulky vegetable food rich in cellulose material that they have a colon ranging in length from four to six feet while the Germans' is from three to four because of eating concentrated food and little cellulose. The shorter the pelvic loop the more completely and promptly does it expel its contents into the rectum.

\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 1917.

### *Inflammation of the Sigmoid.*

The sigmoid, on account of the fact that it is the special abiding place of fecal accumulation and since it retains fecal matter longer than any other portion of the digestive tract, is peculiarly susceptible to the milder and more aggravated forms of catarrhal inflammation, the last mentioned sometimes involving all the coats of the bowel.

Sigmoid inflammations may be divided into two classes, viz., simple and infectious. The simple forms are either catarrhal, ulcerative or interstitial and are nearly always due to a previous constipation with a sigmoid overloaded with hard, dry fecal masses, bringing on erosion of its epithelial surface and stagnation in its circulation.

Simple inflammations may be diagnosed by flatulence, griping pain, frequent desire to defecate, profound constipation, anorexia and stools at times consisting of dry, hard, lumpy fecal matter. Sometimes mucous and blood attend these typical evacuations. A thorough evacuation of the bowels may cause all these symptoms to disappear only to recur with another attack of constipation. The frequent reappearances of the characteristic stools and constipation in time produce the ulcerative type of inflammation and finally the interstitial, which have similar symptoms except in a more aggravated form. With ulcers there is more blood and usually more pain, while with the interstitial the tenderness in the left iliac region is marked and all the bowel coats are frequently involved. This condition often gives rise to diverticulitis and explains the existence of many pelvic adhesions occurring previous to abdominal operations. Incidentally this explanation relieves the surgeon of much unjust criticism aimed at him by the laymen for the appearance of adhesions following operations. Byron Robinson, F. Rawson Pennington and others have called attention to ulcerative and interstitial inflammations of the sigmoid as being potent factors in pelvic disease. Among infectious

sigmoiditis may be mentioned tuberculous, syphilitic, amœbic and others.

In this connection I wish to call attention to a very rare condition which recently came under my observation. A man, aged 55, from Ohio, who had followed the trade of carpentry, very much emaciated and anemic, gave a history of long-standing obstinate constipation accompanied by a great deal of pelvic distress in the region of the sigmoid. These attacks of severe constipation were for a long time alternated with watery evacuations mixed with considerable blood and mucous and for the past few months prior to my acquaintance with the case a watery, bloody mucous diarrhœa developed, attended by excruciating pain in the sigmoid region. The patient ran a temperature ranging from 101 to 102. Upon making a careful examination with the sigmoidoscope, I found that where two arms of the sigmoid loop lay in close apposition, their inflamed serious surfaces had become agglutinated, a diverticulum formed and perforation followed. Undoubtedly this case began as simple sigmoiditis. The treatment of ulcerative and interstitial sigmoiditis, unless complicated with diverticulitis, is to be managed in the same manner as similar stages of proctitis, namely, keeping the bowel free from accumulation of fecal matter and antiseptic irrigations in the knee chest position.

### *Stricture of the Sigmoid.*

This is a condition not frequently diagnosed, but in my opinion existing in varying degree far more commonly than is now generally supposed on account of sigmoid inflammations which are later followed by contractions in the bowel wall. These may be annular, tubular or linear and may arise from simple inflammatory states. They may be simple, tubercular, syphilitic or amœbic in origin.

### *Invagination of the Sigmoid.*

This condition has been encountered rather frequently and is most likely to ap-

pear where the sigmoid is redundant and moderately thickened by chronic inflammatory states. Fixation of the sigmoid is the remedy. The usual form of invagination is into the rectum and is easily diagnosed by the aid of the sigmoidoscope.

#### *Ptosis of the Sigmoid.*

The attention of gastro-enterologists throughout the country is being fastened more firmly every day upon this condition, because of its far-reaching results. The chief symptoms are obstinate constipation alone or alternating with diarrhoea, marked distention, at times tenderness, sensation of weight and dragging in the left iliac and pelvic regions, occasionally a discharge of jelly-like mucous or offensive watery evacuations. Palliative treatment consists in keeping the colon constantly filled with light bulky residue, thereby encouraging free and prompt evacuations of the sigmoid loop. Sigmoidopexy is of course the radical treatment to offer of which there are two recognized methods.

#### *Carcinoma of the Sigmoid.*

This sad state presents the most difficult and serious problem ever encountered in this portion of the digestive tract. The history and sigmoidoscopic examination together with radiographs usually make the diagnosis. Naturally there are only two reasonable courses of procedure open to the physician, palliative and operative, the grave question to decide, being, shall he operate? This decision should be arrived at by a careful consideration of the following points: Extent of the alliance formed between the sigmoid and other organs; length of time the condition has existed; general condition and age of the patient.

#### *Volvulus of the Sigmoid.*

This condition is found in both acute and chronic states and in partial and complete degree. By the acute, I refer to those cases in which the sigmoid loop twists suddenly around itself or a knuckle of the ilium as

sighted by Moynihan, causing complete obstruction. By the chronic, I refer to those cases where the sigmoid loop is twisted on its own axes and becomes adherent, thus lessening the lumen of the gut without producing complete obstruction.

#### *Sigmoid Indigestion.*

This term is a misnomer since no digestion takes place in the sigmoid. It is used in this connection merely to call attention to the fact that patients do complain of gastric distress oftentimes when a searching investigation on every division of the digestive tract above the sigmoid shows conclusively that there is total absence of organic or functional disturbance above that portion and that the distress in the stomach, fullness under the costal arches, depression in the thorax and a disposition to gaseous eructation, together with so-called palpitation of the heart and keen pains running up into the axillary spaces, mean nothing more or less than evidence of gas distension due to partial occlusion of the sigmoid, or to stagnation in its loop or some other form of pathology located there, or either hyperacidity of the stomach which has arisen as a reflex.

Occasional nausea and vomiting accompanied by more or less soreness or pain deep in the pelvic cavity should direct our attention to the sigmoid, and especially if obstipation be present.

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### FACTORS IN UNION AND USE OF TRACTION SUTURE PLATES IN ABDOMINAL INCISIONS.\*

R. R. KIME, M. D., F. A. C. S.,

Lakeland, Fla.

Years ago hernia was of frequent occurrence after abdominal surgical work. The evolution of the technique of the incision and closure of same has eliminated many of the factors that tend to produce hernia, so that it is now of rare occurrence.

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\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.



Today more attention is given to esthetic results, weakened wall, tender areas, unsightly scars, etc.

The disinfection of skin surface, clean-cut incisions, protection of wound, layer suturing with aseptic absorbable sutures, are all factors in the results now secured.

Shaving, soap and warm water, drying skin, then applying Tr. iodine and alcohol equal parts, or McDonald's solution full strength, is the acme of skin disinfection of today.

Sharp-knife clean-cut incision in lines that do least damage to nerves, blood vessels,

able buried sutures in the presence of infection, especially silk or linen that are capable of absorbing and conveying infection along track of suture.

There is one factor that has not been given the attention it deserves, that is putting the incised tissues at rest or as nearly so as possible.

So long as there is special tension or traction on skin sutures, they will cut into the skin and favor infection unless protected in some way.

When they cut through the skin, edges separate and leave an unsightly scar and

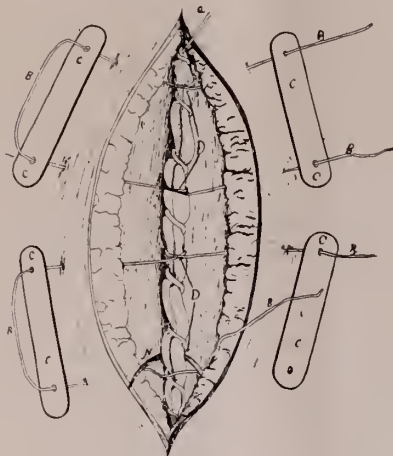


FIG. I.

A—No. 2 chronic catgut in fascia. B—Silkworm gut-stay suture in place. C—Aluminum traction suture plates. D—Loops silk-worm gut in fascia. N—Needle.

muscles and fascial supports are factors worthy of consideration. Layer suturing of like tissues with aseptic absorbable sutures adapted to parts united as to size and absorbability, also care in eliminating all dead spaces are decided advances in closing abdominal incisions.

Sterile catgut dipped in Tr. iodine one part, alcohol three parts, just before operating, rarely if ever gives trouble.

Nonabsorbable sutures buried in the tissues are like a submarine—often give trouble in otherwise smooth sailing, especially in infected areas.

It is a serious mistake to use nonabsorb-



FIG. II.

B—Silkworm gut-stay suture tied on plates. C—Aluminum traction suture plates. E—No. 2 plain cat suture in skin.

especially if any infection occurs and all surgeons know how difficult it is to disinfect the skin and keep it so.

The efforts at vomiting, coughing, sneezing, straining at stool, turning in bed puts extra strain, tension and motion on skin sutures.

Nature usually makes an effort to put inflamed tissues at rest for efficient repair, so will incisions heal best when put at rest.

To accomplish this result as near as possible I have been using some aluminum traction suture plates made by Max Woche & Co. and find they act well so far in abdominal, breast and hernia work.

The same principles should apply equally as well in harelip, cleft palate, and perineal, work also in removal of tumors from skin surface where there is any tension left on skin sutures.

In abdominal and hernia work the open double figure of eight suture is an ideal suture. The loop tightens and holds the fascia firmly giving a base of support, while the plates act as splints to the skin relieving tension on the skin sutures. The traction sutures are not tied over the incision but on the plates, they do not come in contact with skin, hence can not cut it.

In cases of infection, appendiceal abscesses, etc., the traction sutures are introduced at time of operation with a wide margin of skin and when abscess fills up from bottom the traction sutures are tightened as needed to bring skin edges together. This will shorten the period of healing and lessen scar tissue. Silkworm gut of good size and strength is used, one strand making practically two sutures three-fourths to one inch apart, so that an ordinary incision will not need but two strands of silkworm gut for its proper closure.

In drainage cases do not tie the free ends of sutures in hard knot on plates, but make a double turn of the silkworm gut and then pass the free ends around the plate or push the ends under plate from inside out and leave to be tightened when wound is in condition to permit so doing.

Silkworm gut does not absorb and convey infection or cause infection by cutting skin when properly applied with traction suture plates.

In clean wounds this suture can be left as long as needed, in abscess cases it can be left in position indefinitely for bringing skin edges together unless the pus burrows along track of suture.

In abdominal incisions and hernia work the open double-eight suture should be used as illustrated in plates.

The loop in the fascia holds it secure and forms a stay or brace to other structures.

This suture makes approximation and union of fascial structures doubly secure and no possible danger of separation while suture is in position, even if the cat-gut suture has absorbed too soon.

The silkworm gut should be inserted about one inch from incision on skin surface passing deeply through the fatty tissue, needle brought out reversed and passed through the fascial tissues according to location, then carried through the fatty tissue and skin on opposite side; now remove needle and put on the traction suture plate, rethread needle, pass sutures back in same manner to about one inch below starting point, put the second plate on ends of the suture and take two turns in suture and draw taut enough to approximate the skin edges without tension.

A large medium-curved sharp needle is best.

This suture securely binds the fascia, approximates the fatty tissue and skin edges, relieves tension on skin sutures, eliminates dead spaces, prevents cutting in the skin sutures, lessens skin infection and improves materially the esthetic condition of the scar, which is a point of no little importance to female patients.

The figures I and II explain method of introducing sutures and use of the traction suture plates. The plates are made of aluminum, and can be used repeatedly by disinfecting, rubbing them up after each operation.

Since writing the above I notice in May number of *Surgery, Gynecology and Obstetrics* an article by Dr. Schwyzer, of St. Paul, describing a modified figure of eight suture bringing both ends out on same side of incision and tying over gauze to be specially used in fatty abdominal walls.

I also notice in last issue of *Surgical Clinics* an article by Dr. E. Wyllys Andrews recommending tying the severed ends of blood vessels together with the same ligature so as to favor more perfect union and re-establishment of collateral circulation and nutrition as factors in wound repair.

## THE FOOD VALUE AND WHOLESOMENESS OF SELF-RISING FLOUR.

H. O. SNOW, M. D.,

Tampa, Fla.

The recent inquiries on the part of many physicians in regard to the food value and wholesomeness of self-rising flour have led to much discussion.

The food value we would naturally expect to be the sum of the food value of all the ingredients and the wholesomeness to depend alike on its nutritious qualities and the absence of injurious substances. We find, however, there is an additional consideration. The ingredients may interact and deteriorate the product.

Self-rising flour is a mixture of flour, soda and salt, together with an acid ingredient which is generally an impure acid phosphate.

The food value of the ingredients lies in the flour itself. The self-rising ingredients add in no way to the amount of carbohydrates, fat or protein. The flour, usually of a cheaper grade, whitened by long contact with the phosphate admixed, has all the food value of flour of that grade, except as it is affected by the soda present.

Public Health Report No. 333 shows that excess soda destroys the vitamins in food during the short period of cooking and shows that the diseases of malnutrition are caused by a diet lacking vitamins. Inasmuch as manufacturers of self-rising flour seldom employ a chemist to control each mix, it is probable that excess of soda may frequently be found in the manufacturer's flour. This excess soda destroys the vitamins in the cooking.

But what of the long contact in the bag of the unchanged soda on the vitamins in the flour? These are in intimate contact from the time of manufacture until after being sold and it is used in the cooking. Are the vitamins not destroyed before the flour is taken from the bag?

Under any circumstances, both of these dangers can be obviated. The housewife can prepare her own self-rising flour, she can be sure of high quality flour and freedom from excess soda. All that is necessary is to sift together a well-known brand of flour with the proper quantity of a well-known baking powder.

As to the wholesomeness of self-rising ingredients, there is much to consider. The cheapness of the ingredients frequently used in this product does not bespeak the exercise of all the necessary precautions in its manufacture.

The New York Journal of Commerce, in a report of a recent hearing by the Food Standard Commission, states:

"It came out that \* \* \* a great deal of sulphate of lime is really used in cheap baking powders and especially so in self-rising flours, sometimes running as high as 25 per cent. The matter was brought forth that cheap grades of flour are frequently used in such compounds."

Thus it is evident that not only the flour itself, but the leavening materials are inferior in quality.

There is urgent need that those using this product should be warned of its dangers. Labelling requirements should be made a part of our food laws. The label should state the brand, the name and address of the manufacturer, the quality of flour used and the names of all leavening materials. This is no more than most State laws require of baking powder manufacturers and would assist in tracing abuses to their source.

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IT IS NOT NECESSARY TO FORWARD YOUR APPLICATION BLANK FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY, TO THE SURGEON GENERAL. PRESENT IT, TOGETHER WITH THE OTHER PAPERS REQUIRED BY REGULATIONS, TO THE EXAMINING BOARD AT THE TIME YOU APPEAR FOR EXAMINATION.



APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.

Sir:

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....
4. When and where were you naturalized? (For applicants of alien birth only.).....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....
10. If either parent or brother or sister has died, state cause and age in each case :.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation :.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc. :.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates : .....
16. With what ancient or modern languages or branches of science are you acquainted?.....

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\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.

17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result : \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION  
FOR APPOINTMENT IN  
THE MEDICAL RESERVE  
CORPS, U. S. ARMY.

.....Inclosures.

## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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## THE NEEDS OF OUR NATION.

In spite of the publicity given by the press to the immediate needs of the United States Army for medical officers, the medical profession is largely holding back from making applications for appointments in the Medical Officers' Reserve Corps, seemingly taking the stand that the needs of the government are not immediate but can be looked upon as future possible needs. It is a rather deplorable fact that the younger men of the profession have not responded in anything like the ratio that the older ones have. The prominent men in the profession all over the country have responded in a wonderful manner and it is hard to understand why the younger and less prominent should falter. Since THE JOURNAL, under the caption "Selective Conscription for the Medical Reserve Corps of the Army," advocated the adoption of the selective draft system to secure medical officers, considerable agitation has sporadically appeared in various parts of the country in favor of this system. Up to the present time whether we care to admit it or not, the fact stares us in the face that the volunteer method of securing a sufficient number of medical officers for the care of our soldiers has failed. It is not yet too late to turn that failure into success. Surgeon General Gorgas emphasizes the point that in spite of the urgent needs of his department it is not desirable that physicians, whose departure from their homes would entail privation to the civilian population, make application for service, as after the candidate has once been commissioned it is not feasible to entertain applications for exemption from active duty. Certain sections of Florida have responded nobly to the Nation's call, certain others have as yet hardly been heard from. THE JOURNAL believes it to be the duty of every medical man under the age of forty, whose services can be spared from civilian life, to file at once his application for appointment in the Corps.

That the needs of the service are urgent

Next Meeting — Tampa — May, 1918



is evident when it is recalled that a few weeks ago the Surgeon General stated that 20,000 physicians were needed in the Medical Officers' Reserve Corps for the care of our Army. The Council on National Defense recently authorized the following: "Letters have been sent out to all the county committees and special inquiries have been started through the State Committees, medical section, Council of National Defense, in an effort to check up the medical men who have actually accepted commissions in the Medical Officers' Reserve Corps, and the reasons why commissions offered to others have not yet been accepted. Our records indicate that to date something like 11,000 commissions have been offered and that only approximately 5,000 have been accepted. Various general reasons why more commissions have not been accepted are known, but there doubtless exists in different sections of the country special difficulties which should be overcome, and the section is making an effort to determine the exact status of the matter."

G. E. H.

### THE MEDICAL RESERVE CORPS OFFICER.

THE JOURNAL is pleased to note that "An amendment intended to be proposed by Senator Owen to the bill (S. 1786) to amend certain sections of the National Defense Act, would add on page 7, after line 20, at end of Section 10: '*Provided*, That hereafter the commissioned officers of the Medical Corps of the Regular Army shall be distributed in the several grades, as follows: Major generals, 25 per centum; brigadier generals, 25 per centum; colonels, 4 per centum; lieutenant colonels, 8 per centum; majors, 23.5 per centum; captains, 32 per centum; lieutenants, 32 per centum. *Provided further*, That when called into service the numbers of the officers of the Medical Reserve Corps shall be seven to the thousand of men in the National Guard and National Army and the relative grades of the officers of the Medical Reserve Corps

shall be the same as the grades of the Regular Army. The President shall have authority to appoint officers of either corps as 'consultants' with the duty of acting in an advisory capacity, making inspections and reports on medical, surgical, or sanitary questions, and such other duties as may be required by the chief of the Medical Department.' "

The National Defense Act as at present constituted, provides for appointments with the rank of Major, Captain and First Lieutenant, but contains the proviso that the proportion in the indicated grade shall not exceed the proportion for the same grade in the Medical Corps of the Army, with the exception of appointments to the grade of first lieutenant which are unlimited.

It is reasonable to presume that at the time the National Defense Act was drawn up that it was not contemplated that the needs of the service would require a Medical Officers' Reserve Corps of 20,000 or more. It is evident that now when the needs of the Army necessitate a corps of this size that it would be manifestly unjust to limit the ranks of Major and Captain to a few hundred, nor would it be just to restrict promotion to the rank of Major. To the honor of the medical profession it may be said that the very cream of the profession have responded to the call of their country and have accepted commissions in grades below that which they are rightfully entitled to. THE JOURNAL has always believed that in the present crisis the medical man, in fact every man, will receive the consideration due him. Senator Owen's amendment should be adopted with the least possible delay.

G. E. H.

### END THE MONOPOLY ON SALVARSAN.

The Adamson Bill, known as the "trading with the enemy act," has recently been passed by the House of Representatives, is now before the Senate, and will doubtless be enacted into a law. One of its clauses confers authority on the Federal Trade

Commission to grant licenses to citizens of this country to operate patents owned by enemy aliens. Physicians are interested in the bill primarily because it includes the salvarsan situation. The manner in which salvarsan has been supplied in this country has been so arbitrary and the prices charged so tremendously above the actual cost, that we should not be satisfied unless the monopoly is ended so that the drug can be supplied at least at a fairly moderate figure, and the old methods eliminated. It is to be hoped, therefore, that the Federal Trade Commission will not grant exclusive control—that is, exclusive license—to any one person or firm. To do so would simply perpetuate the old monopoly and the old conditions. England has adopted a law which, in principle, is similar to the Adamson Bill, and there several concerns have been licensed to manufacture the product. The same should be done here. The Dermatological Research Laboratories of Philadelphia announce that they can supply Arsenobenzol at \$1.50 a tube, and that there is immediately available a supply sufficient for any demand that may be made. The same laboratories have announced also that in a few months they will be able to supply hospitals for \$1.00 a tube. Considerable responsibility rests on the Federal Trade Commission in this matter, for it is not only a question of monopoly, but also a question of scientific qualifications and ability to make the product on the part of some who may make application. Undoubtedly the commission will secure the cooperation of the United States Public Health Service, under whose supervision these drugs should be manufactured no matter who shall be licensed to make the product.—*Journal American Medical Association.*

#### APPLICATIONS FOR APPOINTMENT IN MEDICAL RESERVE CORPS.

THE JOURNAL publishes in this issue for the convenience of any member a blank application for appointment in the Medical Officers' Reserve Corps of the Army.

We have from time to time put forth in these pages the urgent needs of our government for medical officers. We can not say more at this time other than the present war is not England's war—not France's war—not America's war. It is the war of a United Democracy against Autocracy. It is for the individual physician to say at this time whether it is his duty to offer his services and to do his bit for the big cause. All that is necessary for anyone desirous of making application for appointment in the Reserve Corps is to fill out the application blank having it certified by a notary public, and present it to the nearest examiner. It should be accompanied by two testimonials and a certificate from the clerk of the county that the applicant is licensed to practice medicine in the State. The examiners in this State are The Surgeon at Key West, The Surgeon at Fort Barrancas, and Captain Graham E. Henson, M. O. R. C., Jacksonville.

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#### "KNOCKERS" AND "KICKERS"

Most of the physicians in the training camps for medical officers are happy. Ordered to duty, they severed home ties, closed their offices, made tremendous personal and financial sacrifices and departed to spend three months or even three years in intensive driving, fatiguing studying and training. And yet the attitude of practically every one of them is that of a boy, out camping for a lark, with a certain seriousness of purpose to learn and to improve ever in the mental background. There are a few who kicked when they received their orders, grumbled when they obeyed, fussed when they arrived in camp and "knocked" when they were not "kicking." Kicking in a human being may be an evidence of spirit and then again, as in the army mule, it may be a form of "cussedness." The kickers are not popular in camp, and even when they received the extra privileges they kicked for, no one has envied them the possession. Practically all are beginning to realize that our

government has faced a difficult problem in its best possible manner and are satisfied to make the best of what time and human ability have permitted. Gradually army discipline and intercourse with other and better men are bringing the few grumblers into line. Some of the worst "knockers" are gradually becoming the best "boosters."—*Journal American Medical Association.*

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### "PREPAREDNESS" AND THE EXAMINATION OF RECRUITS.

During the early months of their active service, the most important work for medical officers, both as to the amount and the responsibility assumed, will be the examination of recruits. The first call will be for 500,000 men, in addition to the number necessary to bring the regular army up to the quota provided in the law of June 3, 1916. This still requires approximately 160,000. The examination of 660,000 men is a pretty large undertaking, especially if the examination is made as thoroughly and as carefully as it should be made. The aftermath of the Spanish-American war, with its disabilities already requiring pensions far beyond reason, should be a sufficient warning to our government not to follow the lax methods regarding the enlistment of men which prevailed in 1898. France and England have had a sorry experience, and both have learned at tremendous cost the folly of regarding quantity as of more importance than quality. However, no matter whether the examination shall be rigid and inclusive—to include, for instance, the Wassermann test—or more or less superficial, the fact is that the medical officers, especially the Reserve Corps, have a tremendous and responsible task before them. Undoubtedly many who will be assigned to the examination of recruits have become rusty in diagnostic methods and will need to review some lessons in physical diagnosis. The physical examination of recruits is practically the same as that for life insurance, except that

it is on a larger scale, and in some respects is, or should be, more exacting. All who have now offered themselves, or who are proposing to offer themselves, for the Medical Officers Reserve Corps should adopt the principle of "preparedness" and be ready when called. The War Department has a manual entitled "Rules for the Examination of Recruits" (General Orders No. 66), which contains valuable information. This is supplemented by U. S. Army Recruiting Circular No. 1. These pamphlets can be obtained by addressing the Army Medical Department — or *The Journal* will gladly send a copy on receipt of a stamped, directed envelope.—*Journal American Medical Association.*

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### NATIONAL BOARD OF MEDICAL EXAMINERS.

The National Board of Medical Examiners held its second examination in Washington, D. C., June 13th to 21st. There were twenty-four qualified candidates, twelve of whom appeared for examination, the others having been ordered into active duty between the time of their application and the date of the examination. Of the twelve who took the examination nine passed.

The next examination will be held in Chicago, October 10th to 18th. The regular corps of the Army and Navy may be entered by successful candidates, without further professional examination, providing they meet the adaptability and physical requirements.

There will also be an examination in New York City in the early part of December.

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### OUR HONOR ROLL.

As announced in the last issue of *THE JOURNAL*, "Our Honor Roll" will be published monthly. It will be noted in the following list that a number of additional members of the medical profession of Flor-



ida have been called to the colors since our last issue:

MEDICAL OFFICERS' RESERVE CORPS, U. S. ARMY.

*Home Address.*

Captain Frederick G. Barfield.....	Jacksonville
Captain E. G. Birge .....	Jacksonville
Captain Andrew R. Bond.....	Tampa
Captain Henry Hanson.....	Jacksonville
Captain H. H. Harris.....	Jacksonville
Captain Graham E. Henson .....	Jacksonville
Captain S. M. R. Kennedy.....	Pensacola
Captain Frank R. Maura.....	Ojus
Captain Harry Peyton.....	Jacksonville
Captain M. B. Swift.....	Orlando
Captain Harry F. Watt.....	Ocala
1st Lieut. C. A. Andrews.....	Tampa
1st Lieut. Everard Blackshear .....	Citra
1st Lieut. John E. Boyd.....	Jacksonville
1st Lieut. T. Z. Cason.....	Jacksonville
1st Lieut. Henry B. Cordes.....	Jacksonville
1st Lieut. T. G. Croft.....	Jacksonville
1st Lieut. James S. Davidson.....	Clearwater
1st Lieut. Lester J. Efrd .....	Tampa
1st Lieut. William T. Elmore.....	Gainesville
1st Lieut. Orin O. Feaster.....	Mulberry
1st Lieut. Robert F. Godard.....	Quincy
1st Lieut. H. M. Ginsburg.....	Pensacola
1st Lieut. Paul Goss.....	Mulberry
1st Lieut. John Halliday.....	Tampa
1st Lieut. Maurice E. Heck.....	St. Augustine
1st Lieut. Frank P. Hixon.....	Pensacola
1st Lieut. Roy Howe.....	Daytona
1st Lieut. A. L. Izlar .....	Ocala
1st Lieut. Edward Jelks .....	Jacksonville
1st Lieut. Charles L. Jennings.....	Jacksonville
1st Lieut. Z. V. Johnston.....	Milton
1st Lieut. Richard Leffers .....	Lakeland
1st Lieut. John P. Long.....	Lake City
1st Lieut. John W. McClane.....	St. Petersburg
1st Lieut. William G. McKay.....	Jacksonville
1st Lieut. R. B. McLaws.....	Tampa
1st Lieut. E. H. McRae.....	Tampa
1st Lieut. H. R. Mills .....	Tampa
1st Lieut. L. B. Mitchell.....	Tampa
1st Lieut. Joseph A. Mixon .....	Pensacola
1st Lieut. James B. Parramore.....	Jacksonville
1st Lieut. Archie R. Parrott.....	Jacksonville
1st Lieut. George W. Sherouse.....	Campville
1st Lieut. E. E. Strickland.....	Miccosukie
1st Lieut. G. C. Tillman.....	Gainesville

THE NAVY.

Passed Surgeon W. P. Dey.....	Jacksonville
Asst. Surgeon T. S. Field.....	Jacksonville
Asst. Surgeon J. K. Simpson.....	Jacksonville

NATIONAL GUARD OF FLORIDA.

Major R. C. Turck .....	Jacksonville
1st Lieut. James B. Griffin.....	St. Augustine
1st Lieut. Lucien B. Mitchell .....	Tampa

As we go to press the First and Second Infantry National Guard of Florida and the First Florida Field Hospital are mobilizing. The medical personnel of these units was not available for publication in this issue but will be announced in our September number.

Every effort will be made to keep the Honor Roll up to date and including the name of every Florida physician called to the colors. It is urgently requested that all county secretaries and all readers cooperate with *THE JOURNAL* with this view in end.

## STATE COMMITTEE, COUNCIL OF NATIONAL DEFENSE, MEDICAL SECTION.

The State Committee, Council of National Defense, Medical Section, under the chairmanship of Director Carey P. Rogers of Jacksonville, has compiled an index of all physicians of the State with the view of possessing a medical census of the State. The following letter recently addressed to all physicians of the State under forty-one years of age is self-explanatory:

"DEAR DOCTOR—You doubtless have read in the press from time to time the need of medical officers for the care of our Army as set forth by the Surgeon General.

"Even with the intensive efforts of the various state committees to secure a sufficient number of physicians for the Medical Reserve Corps, the Government is still many thousands short of the number required.

"It was planned at one time to have a medical officer visit the principal points of this State for the purpose of explaining the needs of the Government which are at present urgent.

"Correspondence elicited the fact that at this particular time it would not be advisable to undertake this method of attempting to secure applications for the corps. It was then decided to send out a letter to all physicians of the State under forty-one years of age, setting forth the actual needs of the immediate present. We say the "immediate present," as a great number seem to harbor the opinion that the needs of the Government constitute a need to be considered as a future contingency and that there is no pressing need at the present time.

"Even for the care of the army now mobilizing, at least 10,000 additional medical

officers, to those already commissioned, are required, and as our army expands as it doubtless will have to, even greater demands will be made on the medical profession. The physician coming from civilian life needs training in certain medico-military matters before he can be considered an efficient medical officer. It will therefore be readily seen that it is imperative to fill the Medical Corps to the required quota at once.

"In so far as practical, physicians with a specialty will be assigned duties along the lines of their specialty. In addition it will also be necessary for the Government to develop physicians with inclinations towards certain special branches to efficiency in these branches. As an illustration, the Government has already assigned large numbers of newly appointed officers to courses in Roentgenology in various cities throughout the country, with the view of developing them in military Roentgenology.

"The Surgeon General authorities the statement that in spite of the urgency of the situation it is not desired that physicians who can not be spared by the civilian population make application for appointment in the corps, as it is not desired or at this time considered necessary, to cause any privation or suffering among the civilian population.

"It is desired to especially emphasize that the undersigned are not making any attempt to dictate who should join the colors and who should remain at home. This is a matter for the individual to decide. The fact stares us in the face that up to the present time the individual who should go is not deciding quickly enough to fill the needs of the Government.

"There has already been an agitation declaring that the volunteer method of securing medical officers has failed and calling for a complete registration of all physicians of the country with a view of adopting the selective draft method. It is desired to avoid this step if possible and with this end in view the matter is put before you.

"We are not urging you to go or saying it is your duty to do so. We are, however,

urging those whose conscience dictates that they should do so, to make application at once for appointment in the Medical Reserve Corps.

Sincerely,

"CAREY P. ROGERS, *Chairman*;

"GRAHAM E. HENSON, *Secretary*,  
*"State Committee, Council of National  
 "Defense, Medical Section."*

## SAVING MOTHERS.

More women, 15 to 45 years of age, die from conditions connected with childbirth than from any disease except tuberculosis. About 15,000 deaths from maternal causes occur annually in the United States, and the available figures for this country show no decrease in the maternal death rate since 1900. Maternal deaths are largely preventable by proper care and skilled attendance.

These 15,000 deaths do not measure the full extent of the waste. They are merely a rough index of unmeasured preventable illness and suffering among mothers. Furthermore, certain diseases of early infancy are closely connected with the health of the baby's mother and the maternity care she has received, and these diseases cause about one-third of all the deaths occurring among babies under one year of age. More than 75,000 babies die each year from this group of diseases because they do not have a fair start in life.

The life and health of the mother are in every way important to the well-being of her children. Breast feeding through the greater part of the baby's first-year is his chief protection from all diseases, and mothers are much more likely to be able to nurse their babies successfully if they receive proper care before, at, and after childbirth.

The expectant mother should at once consult a physician. She should remain under supervision so that any dangerous symptom may be discovered as soon as it appears. She should learn how to take care of herself, and she should have proper food and rest and freedom from anxiety. When the baby is born the mother needs trained attendance.

A difficult maternity case is one of the gravest surgical emergencies. Many people do not seem to understand that in any case complications may arise which can be met safely by prompt and skillful scientific care but which at the hands of an unskilled attendant may cost the life of mother or child or both. Even after confinement the mother needs continued supervision and rest until her strength has returned.

Thousands of mothers, both in city and country, do not have the essentials of safety, partly, perhaps chiefly, because they do not realize the dangers involved in lack of care or else accept the dangers as unavoidable. Many women are at present unable to obtain proper care, but when all women and their husbands understand its importance and demand it for every mother, physicians will furnish it, medical colleges will provide better obstetrical training for physicians, and communities will see to it that mothers are properly protected.

Little has been done as yet to show women that much of the waste of mothers' lives and health is unnecessary. Even less has been undertaken by communities to provide protection for them. Many communities which have studied their typhoid and tuberculosis death rates and have undertaken costly measures to reduce them have been heedless of the death rates among mothers. It is not strange, therefore, that since 1900 the typhoid rate for the country as a whole has been cut in half, and the rate from tuberculosis has been markedly reduced, while the death rate from maternal causes has shown no demonstrable decrease.

Just how the importance of adequate maternity care is to be made plain to a community, and just how skilled care and instruction are to be made available for all mothers, are of course local questions to be considered by each community. The prenatal clinics and prenatal nursing which are being developed in many cities suggest a method of supervision and instruction which might well be extended. Even in cities where such work is carried on and where good

hospitals are numerous, the number of mothers reached is small in comparison with the number who bear their children without adequate care.

Difficulties are perhaps greatest in rural districts where the sheer inaccessibility of a physician is often added to the other elements of the problem. Here a public nursing service with headquarters at the county seat, or other accessible town, would probably be the first step, placing at the service of every expectant mother a visiting nurse who is especially equipped to give her information about personal care and to watch for symptoms of trouble demanding medical advice. As such a nursing service develops, its headquarters might become, with the co-operation of physicians, a sort of maternal and child-welfare center to which not only expectant mothers but also mothers with babies could come for instruction, examination, and advice. If no general hospital were conveniently near, a cottage hospital for mother and babies might ultimately form a part of such a center.

A more general use of existing provisions for scientific maternity care and the extension of provisions for such care in all types of communities should serve to reduce the number of deaths among mothers and babies and to improve the health and general condition of children throughout the country. A full discussion of the causes and prevention of maternal deaths and an analysis of available statistics, are contained in a report on *Maternity Mortality*, published by the Children's Bureau.

The Children's Bureau has several publications which are of interest in connection with work for the welfare of mothers and babies. A list of these publications will be sent upon application to the Children's Bureau, Washington, D. C.

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#### CHILDREN IN WARTIME.

##### *How Canada Takes Care of Soldiers' Children.*

How Canada provides for the wives and children of her enlisted men is described in



a report by Mr. S. Herbert Wolfe of New York, prepared at the request of the Secretary of Labor and just published by the Children's Bureau of the United States Department of Labor.

In presenting the report, Miss Lathrop, Chief of the Children's Bureau, says:

"In the fifty years since the Civil War, legislation affecting the family and its economic status has shown marked growth. Mothers' pension laws and minimum-wage laws are recognized examples, and it is acknowledged that their result has not been to pauperize but distinctly to improve the power of the family to protect itself. In view of this tendency it is to be expected that a system of compensation for soldiers and sailors can be developed whereby the Government will make possible for their children the home life and parental care which are the common need of every child."

The report points out that in Canada two notable elements have been added to the Government provision for soldiers and their families: First, insurance on the lives of soldiers is carried by various municipalities, and, second, the Dominion has undertaken as a part of its military system the reeducation, in a suitable occupation, of the disabled soldier so that he can assume again, in whole or in part, the care of his family.

The Canadian compensation for the soldier and his family includes not only \$33 of monthly pay for the private in active service but a separation allowance to his dependents of \$20 a month from the Dominion Government and further assistance in special cases from the Canadian Patriotic Fund.

For example, the wife of a private soldier with three children between the ages of 10 and 15 may receive either \$15 or \$20 from the assigned pay of her husband, \$20 separation allowance, and \$25 from the Canadian Patriotic Fund, or in all \$60 or \$65 a month.

If her husband is killed, she will receive \$40 a month for herself, and an additional \$6 a month for each of her children until

her boys are 16 years of age and her girls are 17 years of age. In addition, if she lives in Toronto or one of a number of other cities, she will receive life insurance. This will be paid to her in monthly instalments unless she shows that she needs the entire amount at once to pay off a mortgage or to make a start in business.

If her husband is disabled, she will receive a special maintenance allowance while he is having medical treatment and learning a new occupation, and when he is finally discharged, if his physical disability continues, a pension will be paid according to the extent of his disability and the number of his children under 16 or 17 years of age.

Mr. Wolfe is an actuary of recognized authority and he has analyzed especially the municipal provision for life insurance by which certain Canadian cities have supplemented the pensions provided by the Dominion for dependents of deceased soldiers. In Toronto, the municipality has not only purchased \$10,000,000 worth of insurance from private companies, but it is itself carrying more than \$32,000,000 worth of insurance. A municipal insurance bureau has been organized and \$2,000,000 worth of bonds have been issued of which the principal and interest are a charge upon the general taxpayers of the city. Every officer and enlisted man residing within the city limits of Toronto who volunteers for overseas service has from the date of his enlistment been protected by a life insurance policy of \$1,000, the protection running from the time of his enlistment to his death or six months after his discharge or resignation.

The report refers also to the fact that each of the European countries makes Government provision for the families of private soldiers and sailors. In Great Britain, France and Germany the amount of the Governmental separation allowance depends upon the size of the family which must be supported.

### CHILDREN'S PLAY—A PATRIOTIC CALL.

"Public provision for recreation is not a luxury to be cut off but a necessity to be conserved." Miss Julia C. Lathrop, Chief of the Children's Bureau of the United States Department of Labor, in discussing the report on Facilities for Children's Play in the District of Columbia, which has just been issued by the Bureau, said today:

"An English authority has lately pointed out the demoralization to boys and girls caused by the breaking down of clubs and the withdrawal to the army of recreation leaders, and he has traced much of the increase in juvenile delinquency in England to the chaos in recreation activities which has prevailed since the war.

"This is a good time to remind ourselves

that the continuance and development of all types of innocent and healthful recreation in every community offer a call to patriotic service for many who can not go to the front. The strain and anxiety which are certain to grow in this country for an indefinite period ahead of us need to be counterbalanced by greater community effort to provide opportunity for wholesome play."

The report on children's play in Washington describes the various sections of the city and the extent of the playgrounds and athletic fields provided by the District Government, by the public schools, and in connection with the Federal parks. It includes an analysis of distances and population in relation to play facilities and makes recommendations for the further development of recreation in Washington.

## REVIEWS FROM CURRENT LITERATURE

### CARDIO-VASCULAR RENAL DISEASE

Barker, Lewellys F.: The Classification and Relations of Cardio-Vascular-Renal Disease. *Southern Medical Journal*, January, 1917, Vol. X, p. 22.

The author comments on the clinical picture of this disease, dividing the manifestations into four stages:

First. *Earliest stages*.—Often discovered at insurance examinations or at regular periods of medical overhauling when a blood pressure above 150 and faint trace of albumin and a few casts is present in the urine, a history of voiding once or twice at night and the urine becoming more abundant and somewhat paler than usual.

Second. *Stage of autopoison arterial hypertension*.—The patient complains of headaches, or sense of fullness in the head, dizziness, irritability, fatigability, insomnia. Blood pressure, systolic, 150-190; diastolic, 10-100; apex beat forcible and second aortic sound; accentuated urine, if repeatedly examined, reveals albumen and casts at times, and there is polyuria day and night.

Third. *Advanced stage before the appearance of threatening complications*.—

Maximal blood pressure over 200, minimal over 100; left ventricle enlarged, ringing aortic second sound; polyuria and nycturia urine pale, low specific gravity, containing little albumin and a few casts, deficient elimination of nitrogen and sclerosed arteriales.

Fourth. *Advanced stage with serious complications*.—With signs of myocardial insufficiency, pulmonary edema, or cerebral apoplexy, or signs of uremia with acute toxic or inflammatory nephropathy.

After discussing the *classification and relations of the disease from the standpoint of pathological anatomy and histology—classifications and relations of the disease from the standpoint of pathological physiology and comments on the etiology and pathogenesis of the disease*, the author concludes: "It would seem probable, then, that the etiological factors that are responsible for the origin of arterial hypertension and of arterial sclerosis are the real causes of the disease we are considering. Probably several etiological factors, rather than a single one, may contribute. Three great

groups of injuries to the blood vessels are under suspicion: (1) Physical and mental overstrain; (2) poisoning by exogenous and endogenous substances and (3) injury from metabolic products produced in excess."

R. H. M.

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Eustis, Allen: The Role of Food in the Etiology of Cardio-Vascular-Renal Disease. *Southern Medical Journal*, February, 1917, Vol. X, p. 96.

Eustis disregards carbohydrates and fats, water and salts as etiologic factors in the production of this disease and devotes his remarks to the consideration of the proteid foods as a causative factor stressing the gastro-intestinal intoxications and absorption of toxic products from an over-abundance of protein substances ingested; summarizing his article as follows: "In cases of cardio-vascular-renal disease intestinal toxemia may contribute to the severity of the symptoms and should be considered in the management of all cases. The stools of man vary in degree of toxicity. Extracts of human feces when injected into rabbits may produce changes in the kidney analogous to those found in cardio-vascular-renal disease in man. Excessive protein food irrespective of intestinal toxemia, overworks the kidneys and is at least a predisposing cause of cardio-vascular-renal disease."

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Vanderhoof, Douglas: Syphilis as a Factor in the Production of Cardio-Vascular-Renal Disease. *Southern Medical Journal*, February, 1917, Vol. X, p. 100.

After reviewing the literature relative to the effects of syphilis on the heart and blood vessels, showing the great changes that take place in the heart and great vessels as a result of syphilitic infection, the author does not incriminate syphilis to any great extent in the production of hypertension and concludes by emphasizing the emergetic treatment of early diagnosticated syphilis as a preventive measure of those later changes in the heart and blood vessels that are due to syphilis as sclerotic aortitis, aneurysm, angina pectoris, myscorditis, etc. R. H. M.

Strickler, C. W.: Significance of Hypertension. *Southern Medical Journal*, March, 1917, Vol. X, p. 191.

Considering hypertension from a clinical standpoint, Strickler says: "Fear, anger, excitement, worry, over-eating, muscular exercise, pain and mental effort are among the temporary causes of this condition, and it is not difficult to see how the more or less continuous action of one or more of these may cause hypertension lasting throughout the day." This signifies the beginning of some auto-intoxication, which is usually, to begin with, of an intestinal character." He thinks that pyorrhea and disease of the prostate may influence the secretion of thyroid and suprarenal glands to excess and these toxins circulating in the system contribute to hypertension and arterio-sclerosis.

R. H. M.

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Geraghty, J. T.: Renal Functional Tests. *Southern Medical Journal*, March, 1917, Vol. X, p. 194.

The author calls attention to the various functional tests for renal secretion and points out their inaccuracies and deficiencies. He relies on the simple water and phthalein corroborates his finding by the estimation of blood urea, insisting that the evidence obtained by these tests should be considered in connection with clinical findings.

R. H. M.

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McLester, Jas. S.: Cardiac Efficiency in Relation to Cardio-Vascular-Renal Disease. *Southern Medical Journal*, April, 1917, Vol. X, p. 295.

Directs attention to embryology of the vascular system, the close relationship of heart and blood vessels, the effect of disease processes on both at the same time and the relation of this diseased process to kidney disease. He then discusses the contractibility, excitability, ability to initiate impulses, conductivity and tone of the heart muscle, indicating anything that disturbs these natural functions as deleterious. He stresses the value of careful and complete examination in order to discover cases early in the disease, urging the use of all diagnostic methods at one's disposal and a serious con-



sideration of all the factors elicited in the patient's life history.

R. H. M.

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Dock, George: Prognosis in Cardio-Vascular-Renal Disease. *Southern Medical Journal*, April, 1917, Vol. X, No. 4, p. 298.

Prognosis depends upon the exact recognition and functional condition of the subject and accurate realization of accumulated data bearing upon the problems involved. Dock divides prognosis into two aspects, general and specific or individual. He thinks that too much stress has been put on the detection of heart murmurs and increased blood pressure bringing about an exaggerated fear and anxiety, and advises more than one examination and careful consideration of general condition of the patient and simple management before rendering a prognosis. Heart murmur, slight hypertension, albumen and cast in the urine, of themselves should not necessarily alarm the physician or patient. Even in cases of incompensation a guarded prognosis is advised because of the remarkably recuperative powers of the heart muscle.

R. H. M.

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Thayer, W. D.: The Management of the Early Stages of Hypertensive Cardio-Vascular-Renal Disease. *Southern Medical Journal*, May, 1917, Vol. X, p. 367.

Divides the cases who will consult a physician into three classes: "Those patients with little or no evidence of vascular or renal change who show a beginning or well marked hypertension. Those cases that show some albuminuria as well as more or less demonstrable changes in the peripheral arteries or those of the eye grounds. Those instances associated with well-marked renal changes with impairment of function, polyuria decreased phthalien output, fixation of the specific gravity." Thayer then discusses the management from the standpoint of regulation of the manner of life; the use and abuse of tobacco, the diet, the use and abuse of alcohol, physical exercise, the avoidance of constipation, removal or control of foci of irritation, avoidance of drug administration that will "knock down the blood pressure,"

and concludes with the advice that these patients must be given detailed, careful directions relative to excitement, mental worry, physical strain, smoking or use of tobacco, immoderate eating and drinking. Gain the patient's confidence, encourage him, remove foci of infection, correct errors of refraction, sinus disease and gastrointestinal disturbances. Relieve the tension of routine business life by vacations and outdoor sports when his condition allows and prevent the patient from developing an undue interest in his own blood pressure.

R. H. M.

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### CHRONIC APPENDICITIS

Granger, Amedee: Unsuspected Chronic Appendicitis Recognized During the Roentgen Examination of the Gastrointestinal Tract. *Interstate Medical Jour.*, Vol. XXIV, 1917, p. 669.

"Cases of unsuspected appendicitis are not as uncommon as might be supposed. During the past three years the writer has discovered unmistakable evidences of chronic appendicitis in ten patients whose gastrointestinal tract he was examining with the roentgen rays for supposed abnormalities in the stomach or the duodenum, and in whom the possibility of appendiceal disease was not thought of. The symptoms in these cases were not constant but such as to suggest gastric or duodenal disease, and, with the exception of two, all the cases examined had been diagnosed, and by competent men, as probable gastric or duodenal ulcers. In the two exceptions, the diagnosis of gastric neurosis had been made. Not one of these patients complained of pain and tenderness in the right iliac region, and there was nothing in their histories which could have suggested that the appendix was the offending organ. The duration of the illness in these cases had been from a few months to nine years, with irregular intervals in the cases of long duration during which the symptoms would disappear altogether. All cases had been under treatment, some for dyspepsia, still others for neurasthenia or gastric neurosis."

The roentgen findings on which the diagnosis of chronic appendicitis was made in these cases were:

A fixed appendix shadow, meaning that an appendix shadow which could not be moved by manipulation during a screen examination, or one found in exactly the same position and location on plates made at several hours interval;

Or an appendix shadow showing persistent kinks or constrictions;

Or an appendix shadow still plainly visible hours after the cecum and the ascending colon could no longer be seen.

When the appendix shadow is not freely movable or when it is kinked or constricted the appendix will be found adherent, and the seat of chronic inflammatory changes.

An appendix that is not empty of the opaque meal when the cecum and the ascending colon are, is a non-functioning appendix, one whose walls have lost their elasticity and contractility. This is always the result of infiltration and thickening of its walls by the chronic and recurring inflammatory conditions of the appendix.

In conclusion we emphasize two facts:

1. That a patient may be suffering from chronic appendicitis and yet have no symptoms suggesting trouble with that organ, but present a clinical picture strongly suggestive of ulcer of the pylorus or of the duodenum.

2. That the appendix shadow is sometimes hidden from view by the shadow of the cecum, and can only be visualized by a thorough emptying of the cecum." L. W. C.

#### REMOVAL OF NEEDLES

Bulkley, Kenneth: A Method of Precision for the Removal of Needles in the Hand; The Use of the Microphone. *Annals of Surgery*, Vol. LXVI, 1917, p. 19.

Numerous devices have been suggested for the localization and the removal of these needles. For accurate localization, the triangulation roentgenograms and the stereoscopic roentgenograms are of the greatest assistance.

"But the greatest difficulty has always seemed to me to be not so much the localization of the needle before incision, as in its recognition at the time of operation. If, on incision, the needle comes at once into view, the problem is solved. But embedded needles are frequently buried in the muscular thenar eminence, lie longitudinally in a lumbrical muscle or flexor tendon, or hide in the most adept manner in one of the interossei. To see a needle so hidden means a large incision, wide retraction, and often considerable injury to muscle or tendon, all these factors tending to lengthen the time of operation and to enhance the possibility of infection. To always be able to feel a needle with the finger partakes of the supernatural. I question either the memory or the experience of the man who states that he has never failed to find a needle by the ordinary dissection method. Of course one may, if fortunate, have the opportunity to work under the guidance of the fluoroscope, but this is not always available."

The use of the microphone has vary materially assisted in the removal of needles in Bulkley's experience of 33 patients; 25 of which have been needles.

In two cases errors not to be charged to the microphone made necessary a second attempt.

"In none of the remaining twenty-three cases have I had much difficulty in localizing the needle. The usual operating time is about ten minutes and until very recently I have never taken more than 20 minutes to obtain contact. In one case I was able to remove a lumbarpuncture needle broken within the vertebral arch without resorting to laminectomy; and in another case to find in granulation tissue without anesthesia a needle that had been already searched for four hours without success. I feel very strongly that a method capable of reducing primary failures from 53 per cent to 3 per cent is worthy of more extended trial."

L. W. C.

**ROENTGEN DIAGNOSIS**

George, A. W., and Leonard, R. D.: The Roentgen Diagnosis of a Pathological Gallbladder. *Amer. Jour. of Roentgenology*, Vol. VII, 1917, No. 7, p. 321.

George reiterates some of his previous statements as to gallbladder diagnosis. Gallstones can be shown in a certain percentage of cases but the gallbladder shadow also can be shown. His premise is that the normal gallbladder does not throw a shadow and a shadow definitely known to be that of the organ mentioned indicates pathology.

He does not think that mere palpation of the gallbladder is sufficient to indicate whether it is normal or not and that only an examination by a pathologist could settle the point.

The roentgen evidence of gallstones is indicative therefore not only of gallbladder disease but a gallbladder shadow is also pathological and can not be eliminated by the surgeon but only by the pathologist.

L. W. C.

**TOXICITY OF SALVARSAN.**

Jay Frank Schamberg, John A. Kolmer and George W. Raiziss: Toxicity of Salvarsan. The Journal of Cutaneous Diseases, Vol. XXXV, 1917, p. 286.

Schamberg, Kolmer and Raiziss have given a very extensive report on their experimentations with salvarsan; this report embraces a consideration of the various phases of salvarsan therapy. The report was made at the fortieth annual meeting of the American Dermatological Association. The published report covers fifty pages of the recent number of the Cutaneous Diseases; it is an extremely interesting report, especially in view of the fact that the investigation was with the American-made salvarsan, known as "Arsenobenzol." The following important subjects were investigated with animal experimentation: "Influence of concentration of solution on toxicity," "Influence of non-neutralized or acid solutions on toxicity," "The influence of the amount of alkali added upon toxicity," "The influence of the purity of the water on

toxicity," "The influence of the age of the solution and the factor of oxidation on toxicity," "Reactive manifestations after salvarsan," "Causes of reaction," "Variations in the medicament and their relations to the immediate reactive symptoms," etc. The following interesting conclusions are given by the authors:

1. Salvarsan may be used in concentrated solutions up to 0.6 gms. in 10 c. c. in animals, without any evidence of toxicity.

2. The failure to neutralize solutions of salvarsan with alkali leads to an increase in toxicity of 50 to 60 per cent in solutions of  $\frac{1}{2}$  to 1 per cent concentration.

3. The addition of moderate excess of alkali beyond the amount required for neutralization does not increase the toxicity, as determinable by the duration of life of the experimented animal. It is possible, however, that it may have other untoward effects.

4. The use of sterile, fresh distilled water appears to possess advantages over sterile, stale distilled waters as regards toxicity, although the difference in our experiments was not pronounced.

5. Salvarsan in alkali solution tends to undergo oxidation on standing, with consequent increased toxicity, but this substance and its congeners vary considerably in the rapidity of oxidation and in the degree of associated toxicity. The drug should be used reasonably prompt after preparation. If two or three hours delay is unavoidable, the solution should be kept in a cylinder, full to the stopper, so that no air is present.

6. Several different types of reactive symptoms may occur after the use of salvarsan: (a) immediate, (b) early, and (c) delayed. The immediate symptoms are due to paresis of the blood vessels; the early symptoms coming on a few hours after the injection are febrile and gastrointestinal, and the delayed symptoms may be referable to the brain or the liver and gastrointestinal tract.

7. There is no one cause of the reaction. The etiological factors in the production of



reactive phenomena may be related to (a) the patient, (b) the technique, and (c) the medicament. We believe that the most important factor in the causation of the reactions is referable to the drug. We believe that the immediate vasoparetic reactive symptoms are due to traces of an unidentified impurity in the drug, which we have for convenience termed substance —X. We are confident that these symptoms are not due to "arsenoxide."

9. Salvarsan and its congeners are not compounds of absolute chemical purity. We cannot, therefore, expect absolute constancy in biological effects.

10. Salvarsan and its congeners may vary, within certain limits, in therapeutic effect, and to a greater degree in toxicity. The ampules obtainable in the open market exhibited striking variations in toxicity.

11. Even the poorest compounds, however, are tolerated by animals in much higher amounts than the maximum dose administered to man, so that there is nearly always a latitude of safety.

12. We believe that the commercial products should be tested out intravenously as well as subcutaneously, and that they should be tolerated by rabbits in the dose of 60 mg. per kilo of body weight.

13. Salvarsan is a safer substance than mercury and can be tolerated intravenously by white rats in fifty times the dose of the latter, weight for weight. J. L. K.-S.

### NEW AND NONOFFICIAL REMEDIES.

**AMPULS CALCIUM CACODYLATE SOLUTION**—MULFORD.—Each ampule contains calcium cacodylate 0.045 gm. in 1 c. c. The H. K. Mulford Co., Philadelphia, Pa.

**BETANAPHTHOL BENZOATE**—ANTHONY-HAMMOND CHEMICAL WORKS, INC.—A brand of betanaphthol benzoate which complies with the N. N. R. standards for this drug. Anthony-Hammond Chemical Works, Inc., New York City.

**BORCHERDT'S MALT EXTRACT WITH COD LIVER OIL.**—A liquid composed of cod liver oil, 20 per cent, and Morcherdt's Malt Extract Plain, 80 per cent. The Borcherd Malt Extract Co., Chicago.

**BORCHERDT'S MALT EXTRACT WITH CREOSOTE.**—100 c. c. contain beechwood creosote, 4 minims per fluidounce, in Borcherd's Malt Extract Plain. The Borcherd Malt Extract Co., Chicago.


**BORCHERDT'S MALT EXTRACT WITH CASCARA SAGRADA.**—100 c. c. contain cascara sagrada, 60 grains per fluidounce, in Borcherd's Malt Extract Plain. The Borcherd Malt Extract Co., Chicago. (*Jour. A. M. A.*, June 23, 1917, p. 1911.)

**CHLORAZENE SURGICAL CREAM.**—It contains chlorazene, 1 gm. in 100 gm. of a base composed of sodium stearate, 15 per cent, and water, 85 per cent. The Abbott Laboratories, Chicago.

**CALCIUM CACODYLATE.**—The calcium salt of cacodylic acid containing from 43.5 to 48 per cent of arsenic in the form of cacodylic acid and free from arsenite, arsenate and monomethylarsenate. It has the mild arsenic action of cacodylates. Calcium cacodylate is white, almost odorless, and very soluble in water.

**KEPHALIN—ARMOUR.**—The hemostatic phosphatid obtained from spinal cord and brain tissue of mammals. It is essentially the same as Brain Lipoid, N. N. R. For a discussion of the actions and uses see New and Nonofficial Remedies, 1917, p. 124, under "Fibrin Ferments and Thromboplastic Substances (Kephalin)." Kephalin-Armour is applied freely to bleeding or oozing surfaces in 1 to 2 per cent suspensions in physiological sodium chlorid solution. Armour & Co., Chicago. (*Jour. A. M. A.*, June 2, 1917, p. 1625.)

**STRONGER THORIUM SODIUM CITRATE SOLUTION.**—Prepared by dissolving thorium nitrate, 15 gm., sodium citrate, 22.5 gm., in water, neutralizing with sodium hydroxide, and diluting to 100 c. c. It is used for obtaining urethral pyelograms.



America, itself an Institution, has been called The Land of Institutions. American Physicians and Pharmacists have reasons to feel proud of one of these—

### THE HOUSE OF SQUIBB.

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FORTY-FIFTH ANNUAL SESSION — TAMPA — MAY, 1918

THE JOURNAL  
— OF THE —  
Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV      St. Augustine and Jacksonville, Fla., September, 1917      Yearly Subscription, \$1.50  
No. 3      Single Copy, 15c.

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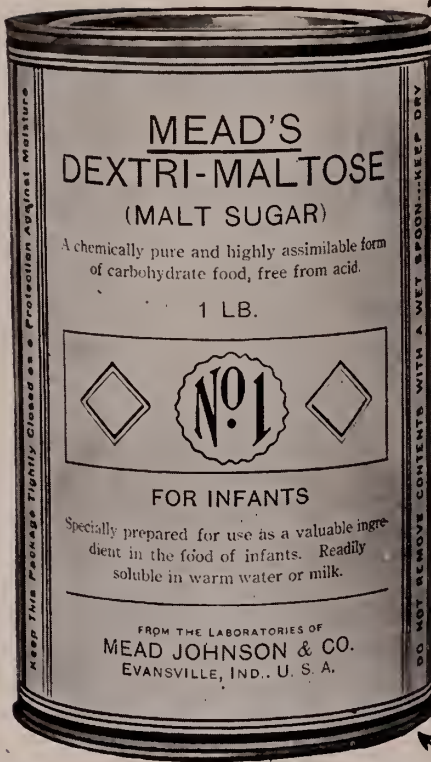
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, September, 1917

Number 3

## MEDICAL PREPAREDNESS IN THE GREAT DRIVE FOR DEMOCRACY.

JOSEPH COLT BLOODGOOD, M. D.,  
Baltimore, Md.,

*Chairman of Committee of Preparedness of the Southern Medical Association.*

These remarks are based on my own observations.

These observations represent an intensive study since August, 1914. The study consists of a careful reading of the literature, personal correspondence with medical men who have had experience at the front, with members of the Medical Corps and Medical Reserve Corps of the Army, and, in addition, a very large correspondence with physicians and surgeons, chiefly in the Southern States, in regard to the Medical Reserve Corps.

The problem of medical preparedness may be divided into three parts: (1) The general activities of the National Red Cross; (2) the special activities of the Red Cross in securing the required number of trained women nurses, and (3) the Medical Reserve Corps.

### *The Red Cross.*

It is very important for the public in this country and the general medical profession to know that voluntary aid in time of war and in any great national emergency or catastrophe is essential.

The one and the best organization for the superintendence of all the activities which have to do with voluntary aid is and should be the Red Cross.

The Red Cross should be able to get its contributions from those who have an income not only sufficient for the necessities of their families but for luxuries. Contributions for the Red Cross should represent

the luxuries abstained from during this great emergency.

There is still another group who should contribute. The majority of men and women who volunteer their services to the country and who are commissioned with a definite rank and definite pay, give their services for a much smaller financial return than they had been previously earning in civil life.

Why should not those whose age, physical defect, or lack of special training prevent them from serving the country, make the same financial sacrifice as those who enter the service and make a voluntary contribution to the Red Cross?

The work of the Red Cross should in a large measure represent the labor of those who in time of peace have idle hours.

No doubt both men and women employed in the great industries concerned with munitions of war and the care of the civic populations, will wish to help with part of their earnings and wish to give labor during their rest periods.

However, it is of the greatest importance that this class of patriotic workers should be protected. They need their rest periods or fatigue will make them stale for the increased efficiency necessary in the demands of this national war.

There are many smaller organizations raising money and stimulating the making of surgical and other supplies, but these organizations should realize the necessity for using the Red Cross for the one channel through which their money and supplies should be transported and distributed.

The Red Cross is an integral part of the War Department and acts under the authority of the Secretary of War and the Surgeon General of the Army.



*Graduate Nurses.*

It would be as much of a mistake to send untrained women to nurse our soldiers in France as to enlist untrained men in the Medical Reserve Corps. Unfortunately the voluntary nurses' aid or partially trained female nurse seems very anxious to be allowed to go to France to help in the care of wounded there, but they do not show the same eagerness to assist in the nursing problems at home.

As long as it is possible to get a sufficient number of trained nurses for the army hospitals in France, it will be unwise to send insufficiently trained women.

There is a large committee of experts considering this difficult problem, but there are a few facts that the public and the profession should know now.

Nurses trained in public health work should not be taken for the army unless proper and efficient substitutes can be found for them, and except in a few instances this seems doubtful. The efficiency of the army depends as much upon the protection and preservation of the health of the nation as on the protection and preservation of the soldier.

As the scarcity of trained nurses increases, the public should not employ or retain them in private homes. Individuals sufficiently ill to require the services of a trained nurse, should go into a hospital where one or two nurses can care for a number of individuals as well as for one individual in a private home.

In some cities where there is a number of smaller hospitals the possibilities of closing one and enlarging another should receive careful consideration. Such a measure would undoubtedly release a number of trained nurses for army work.

Women who have been trained as nurses but who have left this occupation for one reason or another, should send their names to the headquarters of the National Red Cross in Washington, as they might be able

to act as substitutes in home hospitals, and so release nurses for duty in France.

Young women of an age over twenty-five and with a good education, especially those with a college education, should volunteer to enter training schools for nurses. Women of this quality can be more rapidly trained and can be helpful to the nation during this emergency, and can give up this work after the emergency is over.

*The Medical Reserve Corps.*

Granting that with a sufficient number in the Medical Reserve Corps for the needs of the present army of 1,000,000 men, we know that this number is deficient in medical men under the age of thirty-five and deficient in men with certain special training, for example, orthopedic surgeons.

In addition to this, the probabilities are that the medical profession of this country must furnish its quota for the second and perhaps third million men.

Granting that 10,000 medical men is the quota for 1,000,000 men on the firing line, this number of doctors will have to be increased as the reserves are called upon to take the places of the casualty lists. In addition to this we know that our allies—England, France, Italy and Russia—will require from us a large number of trained physicians and surgeons.

It is my own estimate that if we desire to meet the medical situation with efficiency, we should prepare ourselves to select from the medical profession in the United States at least 45,000.

*The Medical Problem.*

Expert opinion states that the winning of this war will depend as much upon the proper care of the soldiers by the medical department as on any other factor.

The care of the soldiers begins with the physical examination, which should be so conducted by a sufficient number of doctors and a sufficient number of experts as to send to France only the young men physically fit.

If our present knowledge of preventive medicine and sanitation is given its opportunity, the soldier who goes to the front should fear no disability, except from a bullet.

If the organization of the activities of the medical department from the firing line to the home hospital is given the means and the men, the wastage from gunshot wounds should be reduced to a minimum.

There are many difficult problems in the treatment of a wound in war. The first is to institute the expert treatment in as short a period of time as possible after the infliction of the wound.

This necessitates a larger number of stretcher bearers and a larger number of young, well-trained surgeons with the troops and in the first dressing stations. The new problems of transportation and the treatment of wounded during the intensity of an action are by no means settled.

The hospital provided with its expert staff of operators and assistants and trained nurses must be moved nearer the front as close as it is possible to find protection. This problem is easier when our army advances and does not retreat.

At the present time the Carrel-Dakin method of treatment of wounds seems to be the one of choice and the sooner this is instituted the better. The surgeons of this country must be taught this method and must be trained in all the new experience with infected war wounds.

There has already been one great contribution to the antitoxin treatment of infected gunshot wounds. Dr. Bull, of the Rockefeller Institute, has apparently discovered the antitoxin for the gas bacillus infection, not only a protective serum but a curative one.

Next to the local treatment of the wound and the transportation of the wounded comes the primary fixation of the extremity during this transportation, and later the proper fixation of the wounded limb during the healing of the wound. This to a larger

extent is a purely orthopedic problem, and at the present time there is a great deficiency in this country of trained orthopedic surgeons.

These facts demonstrate that at the present time the precision of wound treatment, transportation and orthopedic apparatus have by no means reached a position equal to that of preventive medicine and sanitation.

There is a large field for the surgical bacteriologist to follow the lead of Bull and discover, if possible, more protective and curative sera.

There is also a large opportunity for the chemical investigator to continue along the lines of Carrel and Dakin and to discover, if possible, a more effective chemo-therapeutic agent for the continuous antiseptic treatment of wounds, for which at the present we have no curative or protective serum.

There is a large opportunity for experimentation and investigation of the practical problems as to when the wound should be operated on, as to the technique of this operation in the different regions, and as to the method of drainage.

During the healing of the wound, especially on the extremities, there is ample opportunity for improvement and simplification in the methods of fixation.

The orthopedic work has become a first-line problem, and not, as many surgeons in this country formerly considered, a third-line or home problem.

It has been reported that some 300 soldiers were returned to London as hopeless cripples. Trained orthopedic surgeons in the third-line were able to return 225 of these men to the front within one year.

It is easy to imagine that precious time would have been saved and the number would have been increased, if this orthopedic treatment had been instituted in the first-line hospital by specially trained men.

It seems to be the opinion of the authorities in this country that no wounded soldier should be returned home until the most expert treatment in France has demonstrated

that nothing more can be done to restore him to further duty. But even in this group the beginning of instruction and re-education will have to take place with the beginning of his treatment of reconstruction.

For humanity's sake our soldiers must have this effectual medico-surgical care. In addition, it is also an economical problem. It will reduce the cost of the war. Apparently the most expensive thing in this war is the well-trained soldier, but far more important than this consideration is *the winning of the great drive for democracy*, and this practically depends upon reducing the wastage to a minimum. This is largely in the hands of the medical department.

When the medical profession of this country appreciates this necessity, they will hear, understand, and answer the message which calls them to offer its services to the country at home or with the army.

The appreciation of the medical problem is an indication that you have heard the message, and the only answer is a voluntary draft. The medical profession is a special class, but it has not special privileges, only special responsibilities.

A voluntary draft depends upon the proper appreciation by every member of the medical profession of his individual responsibility.

Individual responsibility means universal military training. The latter should be interpreted as a condition in which to meet the necessity of the nation. Every individual, man or woman, in the country should offer to do his or her part, and train for this part. Efficiency of the army in France must not be handicapped by the inefficiency of those at home.

#### *Medical Men Under the Age of Thirty-One.*

Some of these physicians have been drafted and apparently granted the same exemption as any other individual. The probabilities are that these men will ultimately be turned over to the Medical Department of the Army. Every private soldier in the United States Army has a right

to request an examination for commission. If he passes this examination, he must be commissioned as an officer, if there is a vacancy. Medical men, therefore, if drafted, can request this examination, and if they pass it, there is no doubt as to the vacancy.

What is the individual responsibility of a graduate in medicine at the draft age, not drafted, or released on account of some proper exemption? From my study of the question it is the same, and it has no relation whatever to the draft. The medical department of the army needs these young men. Their entering the Medical Corps should not depend upon whether they are drafted or not, nor whether, if drafted, they are exempt for some reason or other.

*The Hospital Interns:* The majority of physicians under thirty-one can make up our hospital interns, and all are agreed that it will be impossible to conduct the civic hospitals without the help of these men. How, then, should this problem be handled for the best interests of the hospital and of the army?

Interns who have served one year or more in a hospital and who desire to enter the Medical Corps of the Army, Navy or Public Health Service should be released at once. The needs of these departments of the government are urgent, and for the individual this is a life career, and he should enter it the moment he has the proper requirements.

Interns who have served one year or more in a hospital who do not desire to enter the Medical Corps of the Army, Navy or Public Health Service should be released for the Medical Reserve Corps of one of these departments, if it is possible to get a less experienced graduate for a substitute.

There are many young physicians in this country who began to practice immediately after graduation, either because they were financially unable to take a hospital year, or because they could not find a vacancy, and perhaps a few because they could not pass the examination. These young physi-



cians will undoubtedly be handicapped in the practice of medicine for the rest of their lives. There is an opportunity to remedy this defect and help both, the individual and the community. Get hold of these men, substitute them in the hospitals for men who have had one or more years' experience, and thus release for the Medical Reserve Corps a group of men almost indispensable for medicine and surgery in war. As soon as these men have had their hospital year they can enter the Medical Reserve Corps.

Every civic hospital should reduce the number of its interns to the possible minimum. Those hospitals in cities associated with medical schools should take some fourth-year students and substitute them for interns physically fit to go into the Medical Reserve Corps. As hospital interns finish their one year's experience, only those physically unfit for the army should be retained by the hospital for the position of senior interns. All the others should be allowed to enter the Medical Corps or the Medical Reserve Corps. No young physician with this training physically fit should waive this duty to his country.

If it is decided not to take women physicians into the Medical Reserve Corps, we should then offer to these young women internships in our hospitals and so release the men.

My correspondence demonstrates that what I have just written is possible and simply a question as to whether a majority of my colleagues will consider it feasible.

#### *Medical Men Between Thirty-One and Thirty-Five Years of Age.*

*Financial Obligations and Dependents:* My own investigation of the situation seems to clearly show that a large number of men at this age who are physically fit and specially needed on account of their training, do not volunteer their services because they have dependents or debts. Apparently the average well-trained young physician starts in practice with no balance in bank, or even with debts. He soon learns that he has an

increasing earning capacity, and he finds it necessary in order to improve himself and his earning capacity, to increase his overhead expenses. In view of the justifiable hope that his income will increase, he does not himself practice economy, nor encourage his growing family to do so—a situation, therefore, entirely different from a similar educated individual on a salary.

It is my opinion that this forms a very large group of physicians.

To meet successfully the medical problem of the war, the probabilities are we shall require more men in this group than in any other. Their youth makes them specially qualified for the physical strain in the zone of advance. Many of them are specialists in the various lines of medicine and surgery.

At the present time it would appear that the "high price of doctors" might interfere very seriously with the work of the Medical Department of the Army. How shall this problem be met? There is no doubt that if the rank of the Medical Reserve Corps is increased, the Surgeon General will be able to offer this group a larger number of captaincies and majorities. However, I am confident from my study that this will not settle the problem. These men must make a financial sacrifice. Their families must live more economically. Some provisions must be made to help them with their debts.

Practically every doctor who goes with the army makes a financial sacrifice. Everyone who remains at home, who is not on a salary, will undoubtedly have an increased income. Some thought should be given to the proper adjustment of this purely financial problem. If it can be adjusted, it will release for the army the men we need most.

At the present time the average age of medical men in training at Fort Oglethorpe is over forty, a little younger in Fort Benjamin Harrison. It is also quite true that the majority of reserve officers sent to England and France are aged less than thirty-five, and that a number in this younger group are retained in base hospitals.

Nevertheless and in spite of this, the chief reason given by a young well-trained physician for not volunteering his services is financial. I have studied this in detail in the group of Johns Hopkins graduates in the Southern States. I hope shortly to publish this statistical investigation.

I have suggested to these men to try to form a partnership, so that if they go, the increased earnings of the partner left at home will meet the financial obligations of both. In a few instances this partnership has been satisfactorily arranged, and splendidly trained and physically fit men have entered the corps. Their practice is being taken care of either by a man aged over fifty-five, or one physically unfit.

*Public Health Service:* No one seems to disagree that the men in public health work should not be disturbed. In fact, it would appear feasible to urge upon the different States to greatly increase all public health appropriations and if necessary to increase the personnel. If the public health officials in this country had sufficient men and means, the reduction in the number of communicable diseases in this country would be so great that a number of physicians in practice would be released for army work, because of reduction of sickness in the civic population. Dr. Williams, the head of the State Board of Health of Virginia, called attention to this in relation to the scare from infantile paralysis.

The Medical Departments of the Army, Navy and Public Health Service of the Government will undoubtedly in the future employ the sanitary experts of the state and county more and more in the sanitation of the now established training camps.

If it is found that the State and County Sanitary Departments, under the direction of officers of the Army, Navy and Public Health Service, can properly protect the soldiers in these camps, medical men in the Reserve Corps will be released for sanitary work in France.

I would suggest to the public health serv-

ice of the states and counties to select physicians physically unfit for work in France for sanitary duty at home, of course, provided that their training is equal to the requirements.

*Medical Schools:* No one for a moment would agree that any teacher essential to instruction in the medical schools should be allowed to handicap its faculties by entering the Medical Reserve Corps for service in France, and apparently the medical schools in this country have given from their faculties up to the danger point.

The question to be considered is: Can more fourth-year men be sent with the base hospitals and receive their teaching there, as has been done by the Johns Hopkins Unit, and thus relieve the home group of teachers? When training camps are near schools, should we not consider the employment of part of the time of teachers and experts in the community for the medical work in the training camp, and so relieve full-time men for service in France? I know that many dislike at the present time to consider anything but full-time reserve officers. But when the demand for 45,000 comes, all of these possibilities will have to be considered in the readjustment and redistribution of the medical profession in order to obtain the greatest efficiency in this great drive for democracy.

At the present moment it is the duty of every graduate in medicine to consider his individual responsibility: First, find out whether he is physically fit. If he is, decide whether he can be spared from the community. If he happens to be in the public health service, or a teacher in a medical school, or the only physician in a rural district, there is no question as to his exemption from service in France.

If, however, he bases his exemption upon financial considerations, or dependents, he should make every effort by every possible means to so adjust his affairs that he can give himself to the service of his country needed because of his age and special train-

ing, and at the same time, through the co-operation and help of his colleagues, protect his family and provide for his debts.

*Base Hospitals:* There seems to have been no difficulty in getting the required personnel for the base hospital units. In fact, the volunteers for places in these units has far exceeded the number required. I am informed on the most accurate authority that a large number of well-qualified physicians and surgeons who have applied for positions with base hospital units and who could not secure such positions because the quota was filled, have not made request for a commission in the Medical Reserve Corps.

To volunteer for a base hospital unit commits the individual as to his personal availability. If he is physically fit and has the proper qualifications to serve with a base hospital, he has burned his bridge behind him, and can offer no legitimate claim for exemption. We have the names and addresses of these men, and I would recommend that they immediately apply for admission to the Medical Reserve Corps.

SPEECH OF HON. ROBERT L. OWEN  
IN THE SENATE OF THE  
UNITED STATES.

We publish below a speech delivered by Hon. Robert L. Owen in the Senate of the United States, in support of a certain amendment to the National Defense Act. The amendment proposes and provides for increased rank for the medical officers of the Army and is reproduced in these columns as it is believed to be of timely interest to the entire medical profession:

SPEECH OF HON. ROBERT L. OWEN, OF  
OKLAHOMA, IN THE SENATE OF THE  
UNITED STATES, FRIDAY, JULY 20, 1917.  
NATIONAL DEFENSE.

"MR. OWEN. Mr. President, I submit the following proposed amendment to Senate bill 1786, proposing to amend the national defense act by fixing the ratio of Army

medical officers with a memoranda of facts and argument justifying the proposed amendment, and ask that it be printed in the *Record*, together with the memoranda.

"The health and the sanitary, medical and surgical care of our beloved young men we are sending to battle is vital.

"The history of all past wars demonstrates conclusively that the line officer, whose mind is steeled and trained to defy danger, can not realize the vital importance of the advice of the Medical Department, and must have the advice come from officers of high or like rank before he will realize the advice must be respected."

There being no objection, the amendment and accompanying papers were referred to the Committee on Military Affairs and ordered to be printed in the *Record*, as follows:

"On page 7, line 20 insert the following at the end of section 10:

"*Provided*, That hereafter the commissioned officers of the Medical Corps of the Regular Army shall be distributed in the several grades as follows:

	Per cent.
Major generals .....	0.25
Brigadier generals .....	.25
Colonels .....	4.00
Lieutenant colonels .....	8.00
Majors .....	23.5
Captains .....	32.0
Lieutenants .....	32.0
	— 87.50
	100.00

"*Provided*, That when called into service the numbers of the officers of the Medical Reserve Corps shall be seven to the thousand of men in the National Guard and National Army and the relative grades of the officers of the Medical Reserve Corps shall be the same as the grades of the Regular Army.

"The President shall have authority to appoint officers of either corps as 'consultants,' with the duty of acting in an advisory capacity, making inspections and reports on medical, surgical, or sanitary questions and



such other duties as may be required by the chief of the Medical Department.

"Memorandum relating to amendment proposed by Senator Owen to the Senate, bill 1186 (amending national-defense act as reported June 8, 1917) to fix ratio of Army medical officers.

"The following memorandum comprises editorials from Victor C. Vaughn, M. D., editor in chief, University of Michigan, Ann Arbor, Mich., professor of hygiene, and data justifying proposed amendment.

"Prof. Vaughn is the chairman of the legislative committee of the general medical board of the Council of National Defense, and his views represent the views of the medical profession of the United States without a known exception. These views are supported by every member of the executive committee of the general medical board of the Council of National Defense, including such men as Dr. Franklin Martin, of Chicago, chairman, one of the most distinguished men in the United States; Dr. William J. Mayo, Rochester, Minn., no abler surgeon in the world; Dr. William H. Welch, of Johns Hopkins University, Baltimore, Md., formerly chairman of the American Medical Association; Surgeon General William C. Gorgas, of the United States Army; Surgeon General William C. Braisted, of the United States Navy; Surgeon General Rupert Blue, United States Public Health Service. Indeed, the members of the medical profession of distinction in every State in the Union and, for that matter, throughout the world:

#### ARE WE TO FORGET THE LESSONS OF 1898?

"This is a question now being asked by medical men all over this country. We have no desire to recall the sad story of the typhoid fever epidemic among our soldiers in 1898 unless we may profit by doing so. It may be well for us to remember that out of a total of 200,000 enlisted men in that war, more than 20,000 developed this disease.

But, says one, vaccination now prevents altogether or greatly lessens the chances of developing typhoid fever, and such an epidemic can never again occur. This may be true, and is undoubtedly partly true, at least of typhoid fever; but there are other diseases for which, unfortunately, we have no protective vaccination. Some of these diseases are diarrhea, dysentery—both bacillary and amebic—scarlet fever, measles, various forms of meningitis, poliomyelitis, pneumonia, tuberculosis, etc. All infections have not yet been conquered. Among the causes of the fearful diseases of 1898—and the causes were many—was the lack of authority on the part of the medical officer. There is abundant evidence of this in various government documents. In the 'Report on typhoid fever in United States military camps in 1898' the evidence that the superior authority of the line officer was responsible in many instances for the insanitary condition of the camps is abundant. This report tells us that many commands were unwisely located, and often this was done in the face of remonstrances on the part of the medical officer. Medical officers of the Seventh Army Corps generally condemned the location at Miami, and yet regiments were kept on this site until they were much reduced by illness, and at Chickamauga some regiments were placed on ground so rocky that the construction of latrines of proper depth and width was impossible. Other camp sites received the surface washings from adjacent commands. Some were contracted into half the regulation space. Many regiments were compelled to remain on the same site until the soil became badly polluted, notwithstanding the fact that there were many broad acres around about, and no hostile army was nearer than Habana. From this report we make the following quotation: 'There were regiments at Chickamauga that did not move a tenth of an inch from the time of arrival in May to that of departure late in August. Requests for change in location made by

medical officers were not always granted. As an illustration under this head, we may call attention to the official records of the Fifth Pennsylvania. This command reached Chickamauga Park May 20, and was, unfortunately, located on low ground. Requests for a change in location were repeatedly sent in during June and July. The soil became muddy, the camp received the washings from camps above, the sinks rapidly filled with water and overflowed, and still requests for change in location were not heeded until August 12. As we have seen, some of the regiments were improperly located from a sanitary standpoint. This was done by superior line officers, and sometimes in the face of protests from the medical officers.'

"This report advised that greater authority be given medical officers in all questions relating to the hygiene and sanitation of camps, and now, as we are going into another war, the line has one general officer for every 167 commissioned officers, while the medical corps has but one, whatever the number of commissioned officers may be, and in an army of 1,000,000, the number of commissioned medical officers will be not less than 7,000.

"The medical profession requests that one-half of 1 per cent of commissioned officers in its corps have the rank of general officers. This seems a modest request and is allowed in the Navy; but, for some unknown reason, has so far been denied the Army. One who has served in the Medical Corps can understand and thoroughly appreciate the hesitancy with which a lieutenant in that corps may recommend to a colonel of the line that a camp site be changed or that some other sanitary improvement is desirable; and one who served in the Medical Corps in 1898 knows full well the reception such a recommendation frequently met at that time, and he can guess at the reception it is likely to receive in the future under similar conditions. If anyone has doubt concerning the attitude of many line officers of high rank

in 1898 toward the recommendations of medical officers, he should read the testimony of Major General Brooke and other officers in command in the camps in 1898. This testimony may be found in the volumes of the congressional inquiry into the 'Conduct of the War Department in the War with Spain,' generally known as the Dodge report.

"The commanding line officer at Chickamauga took no pains in his testimony to show his contempt for the advice of his own medical officers, and this contempt and disregard constituted large factors in filling the hospitals and graves with typhoid cases. We have not place here to quote largely from his testimony, but a few sentences of the testimony of General Brooke may be given:

"Q. Had any of the wells, General, been condemned by the Medical Department prior to your leaving (Chickamauga)?—A. By alleged Medical Departments. Two of them were erroneous, I believe, after investigation made by myself. The one in front of a South Carolina regiment, which, I believe, really to have been perfectly pure water. There was afterwards discovered a surface well which had been walled up and water slipped in from which this regiment—this was reported to me—used the water. That well was not far from a large sink, and possibly on lower ground. I never could understand from my knowledge of rocky strata how that well could have been contaminated. Another well lying on the road between Alexander House and Jay's mill was also condemned. I drank of that well water every time I passed it until somebody broke the pump to pieces. I suppose it was some of our energetic medical fraternity who had spent their time in finding that there was a suspicion of these two wells, and then I did not bother further about it.' (Conduct of War Department in War with Spain, vi, 3080.)

"In this camp there were about 10,000 of General Brooke's troops affected with ty-

phoid fever, about 100 of whom died. This was 25 per cent of his command.

"It probably took a large part of the remaining troops to take care of those who were sick. This excellent general of the line could not understand the folly of medical officers who pointed out that the water was infected and himself drank from infected water, and notwithstanding this, by the providence of God he escaped, because he had had a previous attack of typhoid fever and was himself immune. God bless the line officer and God save the soldiers of the United States from his ignorance of sanitary law.

"On the following page there is a statement of the insanitary condition of Camp Thomas made by the medical officer of the Twelfth New York Infantry. The commanding line officer was so incensed at this report that he said: 'If you will give me a copy of that report, I will see that that young man goes before a court-martial for the sort of statement he has made there, if he is not protected by this commission.'

"This reminds me of the case of Lieutenant Edger, in the Philippines, who stamped out an attack of cholera in an adjacent village near Santa Cruz, where 80 cases occurred the first day and where half the people in the town died in less than 60 days, approximately 1,000 in number. This young medical officer so far protected the American soldiers adjacent that not one of them was lost with cholera, but in his vigilance and strenuous effort to protect them he was court-martialed by the officer of the line in charge and punished on the ground of insubordination when he insisted on taking what he deemed necessary sanitary precaution.

"This young lieutenant is now in the Medical Department, and is available as a witness if any statesman desires to summon him.

"On July 11, 1898, the chief medical officer at Chickamauga addressed a letter to the Adjutant General containing recom-

mendations concerning the improvements of sanitary conditions. In brief, the letter contained the following recommendations:

"1. That the Signal Corps, which had occupied the same site for several months and which was crowded, should be moved.

"2. That selected places should be designated as dumping grounds and all the waste should be collected and deposited on these places instead of being scattered through the camp.

"3. That so far as possible all camp sites should be changed.

"4. That the hospital of the first division of the corps be moved from the unsanitary position they occupied to a more healthful location.

"5. That the village of Lytle, which was a sanitary menace to the troops, should be cleansed.

"6. That all condemned sources of water supply should be effectually closed.

"7. That only filtered or boiled water should be used by the soldiers.

"8. That all hucksters selling doubtful food or drink should be expelled from the camp.

"9. That there should be careful supervision of all food and drink sold in the canteens.

"These recommendations made in July were unheeded at the time.

"In his testimony, General Brooke spoke of the letter containing the above recommendations as follows: 'I did not regard his letter in a very serious sense. I do not know how he came to write it. There was much complaint in that camp from men of his own profession as to his action. He caused me more trouble and annoyance than anyone ever did.'

"Had the recommendations contained in this letter which annoyed the senior line officer been taken seriously in July the fearful harvest of sickness and death in August might have been averted.

"Nineteen years have passed since our little war with Spain, and we have crossed



the threshold of a great war with Germany, Austria, Bulgaria and Turkey. This war begins with the medical officer possessed of no more authority than he had in 1898. Will his recommendations be as futile as they were then? The medical profession has always been responsive to its country's demands, whether in war, in pestilence, in flood, or in famine. Conscription has never been necessary to fill its quota. Medical officers will do their best and will present their recommendations to superior line officers, but they realize that these recommendations are likely to receive scant attention, and that the medical officer will be compelled to work under a heavy handicap. The government stamp placed upon the medical officer indicates the opinion that the government has of the value of his services, and that his recommendations will receive from line officers any different consideration from that accorded them in 1898 is not probable. At present the Army Medical Corps has no representation on the General Staff or in the War College.

"Will it be possible that camp sites, both small and great, will be selected as they were in 1898, without consultation with the Medical Corps? And are we justified in feeling that we may have some reminders of the experiences of 1898? According to the testimony of the Surgeon General recently, given before a medical committee, the relative number of trained medical officers is not as great now as it was at the beginning of the Spanish War. We had then seven per thousand. We have now about five per thousand.

THE ENGLISH RECOGNIZE THE IMPORTANCE  
OF GIVING AUTHORITY TO MEDICAL  
OFFICERS.

"In 1904 the English war office was reorganized by a committee, the chairman of which was Lord Esher. In this reorganization no provision was made for a representative of the medical army corps on the general staff, or what corresponds to our War

College. At the time the surgeon general complained of this action. In reply to this complaint Lord Esher's committee stated that while too much importance could not be attached to the sanitary service of the army in peace or in war, the committee could not accept the views of the surgeon general. Lord Esher's committee continued: 'The army council is not and can not be a representative body as regards the several arms and departments. The royal army medical corps exists to serve the army in a most important capacity, but the first object must be to create and maintain an army, and this is the function of the army council. To admit the principle of representation would destroy the character of the council.'

"This was the opinion of Lord Esher in 1904. Recently (London Times, Feb. 3, 1917) Lord Esher writes as follows: 'How much of the suffering undergone by our soldiers since the war began has been due to the shortsightedness of my committee, and notably of myself, will never be known. Certainly the control of the adjutant general's branch over the royal army medical corps was and is responsible not only for the early failure to grip the medical factors of the war, but they hampered conditions under which the surgeon general has worked. His triumphs and those of the royal army medical corps have been achieved in spite of obstacles that the subordination of science to ignorance and of elasticity to military discipline explains but can not justify.'

THE RANK AND AUTHORITY OF THE MEDICAL  
OFFICER.

"When Stanton was Secretary of War and Hammond Surgeon General early in the Civil War, the latter made a request of the former for advanced rank for medical officers. The great Secretary of War replied with a question: 'Will increased rank make your medical men better doctors?' The Surgeon General replied with another question: 'Does increased rank make line officers quar-

termasters, and those in other corps more proficient?"

"There are two important considerations in regard to the rank and authority of Army medical officers. In the first place, the higher the rank obtainable the better the class of young physicians attracted to the corps. When a young man knows that whatever he may do, however skillful and energetic he may be, whatever discoveries he may make, whatever sacrifices he may undergo, the rank of colonel, with a pay of about \$5,000, is the best that he can possibly look forward to in his old age, it must be acknowledged that the temptation to enter the Army medical service is not great.

"In the second place, and this is of more importance, rank in the Army necessarily means much. A request or a recommendation from a colonel or a general will receive more consideration than when it comes from a lieutenant. Much of the disgrace of 1898 and the disregard shown their recommendations by superior line officers was due to the lack of rank and authority among medical men.

#### THE BRITISH AND FRENCH MEDICAL SERVICE.

"The following is a list of the lieutenant generals and major generals in the British medical service as of October, 1916, taken from the British Army list of October, 1916:

"1. Director general of the British medical service, Sir Alfred Keogh.

"2. Director general of the British forces in France, Sir Alfred Sloggett, rank lieutenant general.

"3. Lieutenant general and director of the British medical service in India, Surgeon General O'Donnell, rank lieutenant general.

"4. Director general Indian medical service, Sir Thomas Pardey Lukis, rank lieutenant general.

#### ON THE KING'S STAFF.

"5. Hon. William Flack Stevenson, surgeon general.

"6. Sir William Babbie, surgeon general.

"7. James Cleghorn, surgeon general.

"8. Hon. Thomas Grainger, surgeon general.

"9. Hon. Peter Stephenson Turnbull, surgeon major general.

#### SURGEON GENERALS RANKING AS MAJOR GENERALS.

"10. Hayward Reader Whitehead.

"11. James Gaussen MacNeece.

"12. William Burney Bannerman.

"13. Thomas Martin Corker.

"14. Sir David Bruce.

"15. Louis Edward Anderson.

"16. Harold George Hathaway.

"17. Walter George Augustus Bedford.

"18. Robert William Steele Lyons.

"19. Richard William Ford.

"20. Tom Percy Woodhouse.

"21. William Grant Macpherson.

"22. Robert Porter.

"23. Thomas Joseph O'Donnell.

"24. Menus William O'Keefe.

"25. Richard Henry Stewart Sawyer.

"26. John Chislett Culling.

"27. William George Birrell.

"28. Francis John Jencken.

"29. Francis Harper Trehern.

"30. William Rice Edwards.

"Since the expansion of the British Army this list has increased, but data are not available. The above data were taken from the Library of Congress, Book G7A2, Class U 11, pages 4, 19, 45, 46 and 1921.

"In the report of the Crimean War, there was an enormous mortality due to defective service in sanitation and in the medical, surgical and hospital services.

"The medical officer had no authority whatever, and the line officer did not realize the effect of disregarding medical advice, and the medical officer had no rank or dignity to emphasize his advice. The same distressing consequences ensued from the same causes in the American Civil War, in the South African War, in the Spanish War and recently in the Mesopotamian campaign. (See report below.)

"I submit a very brief extract on the recent British disaster in Mesopotamia, due to neglecting health of men:

"Report of the commission appointed by act of Parliament to inquire into the operations of war in Mesopotamia, 1917.

"(Extract from the Vincent-Bingley Commission's report on the Mesopotamia expedition (sec. 110, pp. 133-163), Library of Congress.)

\* \* \* \*

"There is abundant evidence that \* \* \* lack of coordination have been important factors in the situation. Conferences were held at headquarters from time to time, and plans were considered. It is stated, however, that Surgeon General ——— did not attend these conferences, except when the subjects discussed related directly to the medical administration. He was thus less in touch with the general situation than other heads of administrative services, and we think that this had an unfavorable influence on the working of his branch.

"Section 111: The chief of the general staff, India, made special inquiries as to whether he was satisfied that the general staff was in sufficiently close touch with the medical services to insure that the latter knew when extra demands were likely to be made on them. General ——— replied that he was 'perfectly satisfied.' We regret that we can not indorse this view, as there is evidence that on this and on other occasions the want of coordination and cooperation between the different branches of the staff, particularly between the inspector general of communications and the medical services, was the source of great inconvenience.

\* \* \* \*

"Section 58: We doubt whether the military authorities in Mesopotamia treated the medical services with much consideration in this matter, or whether they sufficiently realized the need for such steamers.

"Paragraph 175: The medical personnel and subordinate staff have always been deficient in numbers \* \* \* and it has only

been the continued and untiring labors of a devoted but overworked staff that has again and again prevented an absolute breakdown.

"Paragraph 176: We consider that the rigid economy which before the war was exercised and the spirit which this policy has engendered as to the comparative merits of economy and efficiency have contributed materially to the breakdown.

"Paragraph 172: We are satisfied that the failure in the medical organization had a material effect on the morale of the troops.

"Part section 123: Surgeon General ——— did not represent with sufficient promptitude and force the needs of the services for which he is responsible, and in particular failed to urge the necessity \* \* \* with that insistence which the situation demanded. Decision: We indorse the finding as regards Surgeon General ———, who, in our judgment, showed himself unfit for the high administrative office he held.

"Memorandum obtained from British medical officer of high rank on my request for it.—R. S. O.

#### THE SENIOR RANKS OF THE BRITISH MEDICAL SERVICE.

"In the British Army at present there are three surgeon generals with rank of lieutenant general; that is, the director general (Sir Alfred Keogh) at the war office, the director general of British forces in France (Sir Arthur Sloggett), and the director of British medical services in India (Surgeon General O'Donnell).

"Another officer, Sir Thomas Pardey Lukis, with rank of lieutenant general, is the director general of the Indian Medical Service.

"There is also a considerable number of surgeon generals with rank of major general. I think the actual number is 19, but I have not a recent army list in my possession. These officers all hold important posts, the following are some of the principal appointments:



"(a) Each army on the western front (we may assume an army to consist of about 200,000 troops) is furnished with a surgeon general as director of medical services of that army. This officer commands and is responsible for the entire medical service in the army in which he is appointed; he is on the headquarters staff of the army, and is the responsible advisor of the general commanding the army on all questions relating to the care and welfare of the troops, the prevention and dealing with epidemics, arrangements for the collection and evacuation of casualties in sick and wounded, the provision and establishment of field ambulances, casualty clearing stations and hospitals in the army area, the provision of ambulance trains, the establishment of convalescent camps and very numerous other important matters.

"(b) A full colonel, army medical service, is with the headquarters staff of each corps and division, and his duties relate to all sanitary and medical matters in the formation to which he is appointed. He is also the medical advisor of the general commanding the corps or division.

"It would appear very advisable, in fact absolutely necessary, that the above officers hold the senior rank which they at present do.

"An enormous amount of responsibility rests in their hands, and they are daily called upon to give opinion or advice on matters involving very weighty consideration and vital importance not only of vast importance to the well-being and efficiency of the army but also inception and schemes involving the expenditure of millions of pounds, e. g., the defensive measures against gas attacks, and the provision of gas masks and respirators have throughout been carried out by the medical service of the army, this being only one—and a comparatively minor—example of the many questions which have arisen.

"Let us suppose—for the purpose of argument—that these officers did not hold the senior rank which they do at present; would

their opinion carry sufficient weight? For example, suppose that the director of medical services of an army held the rank only of colonel every general commanding a division in that army, and also even every brigade commander, would be senior in rank to him. Could it reasonably be expected that the opinion of the director of medical services for the army would then carry the weight and authority which it does at present?

"In my humble opinion there can be only one answer, especially when it is borne in mind that these officers are specially selected for their high rank on account of their abilities and previous experience.

"(c) Other surgeon generals, with rank of major general, are serving in the following appointments:

"1. As director medical services on the lines of communication in France.

"2. As deputy director general at the war office.

"3. As director medical services in Egypt.

"4. As director medical services in Salonica.

"5. As director medical services in Mesopotamia.

"6. As director medical services in three commands in India.

"7. As director medical services in command in England, etc.

"Similar arguments in favor of high rank hold good with regard to all these appointments.

"Lastly, and this is a point which is deserving of sympathetic consideration, surely it is advisable to provide a certain number of higher ranks in the medical service, as in other branches of the army.

"The provision of these higher ranks and appointments which would be filled absolutely by selection, would furnish a goal for laudable ambition and an incentive to strenuous scientific work throughout the whole of an officer's service, and can, in my opinion, be productive of nothing but the very best results.



"The present campaign has furnished innumerable instances of the vast importance of the Medical Service and of the high standing and authority which it holds with the rest of the army.

"The French Army also dignified the medical department by providing for officers of the rank of major general and lieutenant general. This is also true of the Italian, Austrian, German and Japanese Armies for the same reasons.

"On January 16, 1917, Secretary of War Hon. Newton D. Baker strenuously urged upon Congress legislation to give the Army equalization of rank in the higher grades with that of the Navy on the ground that otherwise the detrimental effect on the Army would be too clear to require more than a statement. He said:

"I wish to strongly emphasize that without legislation giving the Army equalization of rank in the higher grades with that of the Navy, the branch of the government of which I am in charge will be done an obvious injustice, the detrimental effect of which to the Army is too clear to require more than a statement. All the reasons which have been urged for the creation of these grades in the Navy so as to efficiently handle the units properly composing a command to be under the direction of such officers of the Navy are present in at least an equal degree in the Army. As Congress, after a full consideration of the subject, wisely decided on the advisability of giving the Navy these grades in order that it may be properly and efficiently officered, for similar reasons it should now provide similar grades for the Army.

"The embarrassment which arises in every branch of the service when brought in contact with other officers of foreign service of superior grade but not existing in our service is identical.

"But the constant embarrassment arising between the two services in the disparity of rank is too apparent to call for more than mention.

"If in all those joint matters in which the Army and the Navy are concerned the Navy, by reason of the position of the superior grade is entitled to outrank the Army, the Army must perforce regard itself and be looked upon as a subordinate branch, and this is too inequitable."

"This argument of the Secretary of War applies with precisely the same force to the organization of the Medical Department, which should not be put in the attitude of being subordinate in the field for which it is responsible. It should have a commanding position of dignity and responsibility, and when the recommendation is overruled it should be overruled by an officer of equal rank in the line for military purposes only, and then that officer should be personally responsible for the consequences, and if he errs should be subject to immediate court-martial.

"There is here submitted a comparison table of the percentage composition of the Medical Corps of the United States Army (existent and proposed) as compared with the principal foreign armies and the United States Navy, from which it will be seen that the Navy already has the proportions which I have proposed in the pending amendment and with the percentage of major generals proposed is surpassed by the Italian Army, the French Army, the British Army, the Austrian Army and the Japanese Army, and that Italy, France, Great Britain, Austria and Japan all have officers of the rank of lieutenant general under the medical department of the army while the United States has none.

"WAR DEPARTMENT,

"OFFICE OF THE SURGEON GENERAL,

"ARMY MEDICAL MUSEUM AND LIBRARY,

*"Washington, June 13, 1917.*

"HON. ROBERT L. OWEN,

*"United States Senate, Washington.*

"DEAR SENATOR OWEN: In compliance with your request of this date, I have pleasure in handing you herewith the desired



data on medical organization in foreign armies. These data have been compiled from the latest sources at our disposal. The library receives only printed literature on the subject as it is published from time to time. It is thought that the Army War College might have in its possession recent confidential reports by military observers in Europe which might considerably modify the figures found by us. I trust, however, that upon the inclosed sheets you will find the information which you are seeking.

"Very sincerely yours,

"C. C. McCULLOCH, Jr.

#### I. AUSTRIA-HUNGARY.

##### *Peace strength of the armies of the Dual Monarchy.*

"Officers and men:

Common army (of both countries).....	370,725
Austrian army .....	55,195
Hungarian army .....	42,800

Total .....	468,720
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The titles, ranks, and numbers of commissioned medical officers are:

Titles.	Common army.	Austrian Army.	Hungarian Army.	Total.
Lieutenant general....	1	.....	.....	1
Major general .....	8	1	1	10
Colonel .....	50	6	8	64
Lieutenant colonel....	75	15	10	100
Major .....	154	19	22	195
Captain .....	711	152	122	985
Lieutenant .....	229	10	15	254
Total .....	1,228	203	178	1,609

#### II. GERMANY.

##### *Peace strength of the army.*

Officers and men .....	644,267
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The titles, ranks, and numbers of commissioned medical officers:

Lieutenant general .....	1
Major general .....	4
Colonel .....	25
Lieutenant colonel .....	60
Major .....	494
Captain .....	640
Lieutenant .....	1,143

Total .....	2,367
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Figures taken from budget of 1912.

#### III. ITALY.

##### *Peace strength of army.*

Officers and men (budget of 1912).....	252,340
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The titles, ranks, and numbers of commissioned medical officers:

Lieutenant general .....	1
Major general .....	3
Colonel .....	26
Lieutenant colonel .....	36
Major .....	113
Captain .....	314
Lieutenant .....	274

Total .....	767
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#### IV. JAPAN.

##### *Peace strength of active army.*

Officers and men .....	235,500
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The titles, ranks, and numbers of commissioned medical officers:

Lieutenant general .....	2
Major general .....	9
Colonel .....	23
Lieutenant colonel .....	39
Major .....	125
Captain .....	473
First lieutenant .....	279
Second lieutenant .....	281

Total .....	1,231
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"The Army List and Directory of the United States, May 20, 1917, shows:

##### "GENERAL LINE OFFICERS.

"Seven major generals of the line.

"One major general in the Quartermaster's Corps (subject to detail from the line at a later date).

"One major general in the Coast Artillery Corps.

"A total of nine major generals pertaining to the line.

"There are 21 brigadier generals of the line.

"There are two brigadier generals of the Quartermaster Corps, one brigadier general of the Signal Corps, one brigadier general of the Ordnance Corps, one brigadier general of the Inspector General's Department, one brigadier general of The Adjutant General's Department, and one brigadier general of the Bureau of Insular Affairs. (All of these officers are subject to detail from the line when the permanent officers shall have been exhausted.)

"There are twenty-eight brigadier generals pertaining to the line.

"There are 7,220 commissioned officers in the Army. Of these, 17 belong to the Judge Advocate General's Department; 994 to the Medical Department (including in this strength 135 Medical Reserve officers and 117 dental officers; the officers of the Veterinary Corps are not included here, nor are they apparently included in the authorized strength of the Army in this Army List). There are 302 officers of the Engineers. This makes a total of 1,313 officers. This subtracted from 7,220, the total number of officers, leaves 5,907 officers.

"Nine major generals of the line to 5,907 line officers.

"One major general of the line to 656 line officers.

"There would be 15 major generals of the line to 10,000 line officers on this proportion.

"Twenty-eight brigadier generals of the line to 5,907 line officers.

"One brigadier general of the line to 211 line officers.

"There would be 47 brigadier generals of the line to 10,000 line officers on this proportion.

"Fifteen major generals of the line to each 10,000 line officers.

"Forty-seven brigadier generals of the line to each 10,000 line officers.

"Sixty-two general officers for each 10,000 line officers.

"The above general officers are in command of 137,855 enlisted men and must be expanded as the Army is enlarged. The bill for this expansion is now pending as Senate 1786. This bill, if unamended, would provide only one general officer of the Medical Department for over 10,000 medical officers of the Medical Department, including the officers of the Medical Reserve Corps for the National Guard and National Army.

"The above record justifies the amendment which I now propose. The amendment meets the cordial indorsement of the medical section of the Council of National Defense."

## WAR MEETING FOR HEALTH OFFICERS.

A war meeting will be held at Washington, D. C., October 17-20, 1917, by the American Public Health Association. This will replace the annual meeting which was to be held at New Orleans, La., December 4-7, 1917.

The papers and conferences will deal largely with the health problems created by the Great War—the food supply, communicable diseases among soldiers, war and venereal disease, war and the health of the civil population, etc.

President Wilson has said: "It is not an army we must shape and train for war; it is a nation." Go to the Washington meeting; then come back and do your bit!

Washington will be crowded and those interested are urged to reserve hotel accommodations at once. It will be easy to cancel reservations, but it may be impossible to obtain rooms at the last moment. Any hotel or railroad can give a list of Washington hotels.

Preliminary program will be automatically mailed to all members of the A. P. H. A. about September 15th. Non-members may receive them free by writing to The American Public Health Association, 126 Massachusetts Ave., Boston, Mass.

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AFTER THE WAR IS OVER. — One eminent physician, who is over age, facetiously remarked that "after the war the fellows who went will do all the talking, while those who stayed at home will not have anything to talk about." There is no question that the men who serve in the army will be drawn together by strong ties, that they will be looked up to and revered as patriots, and that through the veterans and other organizations they will form a select class which will be envied by those not so fortunate.—*The Southern Medical Journal*.

## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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GRAHAM E. HENSON, M. D., Secretary-Treasurer, ....  
    *Jacksonville*

### EXECUTIVE COMMITTEE

F. F. FERRIS, M. D. .... *Apalachicola*  
W. E. ROSS, M. D. .... *Jacksonville*  
E. VAN HOOD, M. D. .... *Ocala*

### COUNCILLORS.

First District—Escambia, Santa Rosa and Walton Counties: J. Harris Pierpont, M. D., Pensacola, 1920  
Second District—Franklin, Gadsden, Jefferson, Leon, Liberty and Waukulla Counties: F. F. Ferris, M. D., Apalachicola ..... 1921  
Third District—Columbia, Hamilton, Madison, Lafayette, Suwanee and Taylor Counties: W. C. White, M. D., Live Oak ..... 1921  
Fourth District—Duval, Clay, Nassau and St. Johns Counties: Gerry R. Holden, M. D., Jacksonville. .... 1918  
Fifth District—Citrus, Hernando, Lake, Marion and Sumter Counties: E. Van Hood, M. D., Ocala. .... 1919  
Sixth District—Hillsborough, Pasco and Pinellas Counties: Thomas Trulsen, M. D., Tampa. .... 1919  
Seventh District—Brevard, Orange, Osceola, St. Lucie and Volusia Counties: David Forster, M. D., Hawks Park ..... 1917  
Eighth District—Alachua, Baker, Bradford, Levy and Putnam Counties: A. H. Freeman, M. D., Starke, 1920  
Ninth District—Calhoun, Holmes, Jackson and Washington Counties: J. S. McGeachy, M. D., Chipley, 1918  
Tenth District—DeSoto, Lee, Manatee and Polk Counties: R. L. Cline, M. D., Arcadia. .... 1920  
Eleventh District—Dade, Monroe and Palm Beach Counties: W. R. Warren, M. D., Key West. .... 1921

### COMMITTEE ON SCIENTIFIC WORK.

H. MASON SMITH, M. D. .... *Chattahoochee*  
JOHN S. HELMS, M. D. .... *Tampa*  
W. R. WARREN, M. D. .... *Key West*

**Next Meeting — Tampa — May, 1918**

## A MEDICO-MILITARY NUMBER.

This issue of THE JOURNAL is made up entirely of subject matter of medico-military interest and is dedicated to those members of the Florida medical profession who have answered their country's call and aligned themselves with some branch of the military or naval services.

Just as our forms were closing, a report from the Medical Section, Council of National Defense, shows that Florida is well at the head of the list of States in the ratio of physicians to medical population offering their services in the Medical Reserve Corps of the Army with a percentage of 14.6. THE JOURNAL is well pleased with this most excellent showing and takes pride in the fact that it has been an active factor in securing recruits from the profession of the State for a branch of the service whose duty it will be to keep the "Sammys" in good fighting trim.

We wish to especially call our readers' attention to the most excellent and interesting article from the pen of Major Joseph Colt Bloodgood, Medical Reserve Corps, entitled "Medical Preparedness in the Great Drive for Democracy."

This article should be read by every physician in Florida, or better still, by every physician in the United States. Major Bloodgood's interest in, and labor for, the Medical Reserve Corps has been untiring ever since, or even before, it was seen that the necessity had arisen for the creation of an immense medical reserve. An analysis of his article will reveal that he has made a most careful study of the many problems that have to be worked out both by those interested in building up the Reserve and by the individual physician who is confronted with the fact that, to do his duty by his country it is imperative he offer his services to the government.

After discussing the general and special activities of the Red Cross as a part of "Medical Preparedness in the Great Drive



for Democracy," Major Bloodgood deals with the opportunities offered the medical man in the present war to build additional monuments to the glory of the medical profession. We are too much inclined in the routine of civil practice to assume that all that is worth while in the broad field of preventive medicine has been worked out and that there is nothing much left to be accomplished. The recent apparent discovery by Doctor Bull, of the Rockefeller Institute, of the antitoxin for the gas bacillus infection is cited by Major Bloodgood as an illustration of the possibilities of research work on the present battlefields of Europe.

The author demonstrates that he has made a careful study of the many vexing problems that confront the individual physician, and while it is not necessary to discuss them in detail, THE JOURNAL is satisfied that many physicians who have for one reason and another held back from placing their services at the disposal of the government cannot, after reading Major Bloodgood's article, conduct careful introspections without at once filing their applications for appointment in the Medical Reserve Corps.

The Surgeon General of the Army has stated that one-fifth or 20 per cent of the medical profession of the United States are required to bring the Reserve Corps up to the required strength. Florida leads now in the percentage of physicians having offered themselves for military duty. Let her be the first to give the required 20 per cent of her medical population to the medico-military service of her country. G. E. H.

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#### THE FLORIDA MEDICAL PROFESSION AND THE MEDICAL RESERVE CORPS OF THE UNITED STATES ARMY.

The Florida medical profession has reason to feel proud of the manner in which the members have responded to the call of their country in its hour of need. The strug-

gle we are about to enter is a gigantic one and the burden to be borne will be heavier on the medical profession than on any other. A tabulation of the States has recently been issued by the Medical Section, Council of National Defense. The tabulation gives the number of physicians resident in each State, the number that have applied for military service and the ratio percentage. The tabulation is corrected up to June 29th and shows Florida to be third in line with 9.3 per cent of her physicians having applied for service. Arizona leads with 9.7 per cent, and Maryland second with 9.4 per cent. A comparison of what has been accomplished in Florida with that in other Southern States is of interest. North Carolina is credited with 6.5 per cent, Mississippi with 5.5 per cent, Louisiana with 5.4 per cent, Virginia with 4.0 per cent, South Carolina with 3.9 per cent, West Virginia with 3.8 per cent, Alabama with 3.3 per cent, Tennessee with 2.8 per cent, Georgia and Kentucky being tied with 2.6 per cent.

Since the above tabulation was completed, additional physicians in this State have applied for military service, bringing the ratio of physicians applying for service to those resident in the State up to 12.7 per cent.\* We publish elsewhere in this issue of THE JOURNAL a complete list of all Florida physicians who have been recommended by the Surgeon General of the Army for commissions in the Medical Reserve Corps.

*The Journal of the American Medical Association* in a recent issue very properly takes the stand that it is "not yet time to relax," stating editorially:

"We can be proud of the fact that there is an ample supply of physicians for the immediate needs of our army, but we must not cease recruiting. An analysis of the needs of our army made on June 1st indicated that 20,000 medical officers would be

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\*Note. Just as we go to press a report from the Medical Section, Council of National Defense, shows Florida to be well at the head of the list of States with a percentage of 14.6.

required to complete the program for the raising of the army outlined by Congress and the President, that is, the regular army, the National Guard and the full national army. This is a liberal allowance since the maximum army in the field as at present defined by law is 1,700,000 men. Adopting the minimum estimate that there are now 13,000 medical officers commissioned in the reserve corps, we should continue our efforts not only until the full 20,000 physicians are provided but also a surplus. It is well to have a big reserve."

The only criticism that can be made of this statement is the reference contained therein that "there are now 13,000 medical officers commissioned in the reserve corps." Our esteemed contemporary falls into an error that is quite a common one of the medical press of the country in not recognizing the difference between recommendations for commissions and the acceptance thereof. Under date of August 23rd, the Medical Section of the Council of National Defense issued a statement that "The number of medical reserve officers so far commissioned has passed 9,000. The number recommended by the Surgeon General for commissions is approximately 15,000." It is believed that most of those not already having accepted their commissions will ultimately do so. The 6,000 who have up to date failed to accept their commissions are, however, not an asset of the Surgeon General's office until they complete their enrollment by doing so.

The writer has been informed of one or two instances where married physicians, subject to draft in the National Army, have applied for and received commissions, but are delaying action in accepting them until such time as their claims for exemption are passed upon by the local boards. In the event that they are exempted from service it is stated they have no intention of accepting their commissions, but in the event that their exemption claims are disallowed, they then intend sending in their acceptance. It

is not believed that there are a sufficient number of commissions issued to "patriots" of this class to embarrass the Surgeon General, but no words of condemnation are too harsh to apply to such methods of accepting or declining service.

There is little doubt that in a spirit of enthusiasm and patriotic fervor many physicians in this and other States have entered the service when their duty was more properly to remain at their posts. There is also no doubt that in spite of the very excellent showing this State has made up to the present time, there are still many others who should come forward and offer their services, for "It is not yet time to relax."

G. E. H.

#### OUR JOURNAL FACING A CRISIS.

With the large number of the medical profession of this State having entered or about to enter the military service of the country, there is no gainsaying the fact that THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION is facing a crisis. The writer is, however, convinced that if the members of the profession remaining in the State will take an active interest in the affairs of THE JOURNAL and the organization it represents, both will be safely able to weather the storm until such time as it subsides and we return to normal conditions at the close of the war. We believe that the publication fills a distinct need and that it has well served the purpose for which it was established. While we are aware that there have been criticisms, some unjust—others probably well founded, it is our belief that the Florida Medical Association as a whole is well pleased and satisfied with the publication as it appears from month to month. It may not be remiss at this time to discuss the value of THE JOURNAL as an asset of the Florida profession, what it has already accomplished in actual deeds done, together with the aims and ambitions for the publication that are in the minds of those directly concerned with its management.

THE JOURNAL made its first appearance during the month of July, 1914, and has appeared monthly since that time. It supplanted the old volume of "Transactions of the Association" which for several years had been published annually at an expense to the Association of between five and six hundred dollars. With the exception of a few enthusiasts, these volumes were hardly looked into by those receiving them. At the time THE JOURNAL made its initial appearance the membership of the Florida Medical Association was in the neighborhood of three hundred and fifty, and had fluctuated between three and four hundred for many years previous. At the present time we have a membership of seven hundred and twenty-four, this increase in membership being a steady and continuous growth ever since the establishment of THE JOURNAL. Where the old volume of "Transactions of the Association" held nothing to bind the members to the Association, THE JOURNAL, coming out as it does each month, has served to stimulate interest in organized medicine and hold members within the organization once they became affiliated.

The present cost of THE JOURNAL to the members of the Association is nothing over and above what the annual dues of the organization have been fixed at for the past many years, THE JOURNAL being maintained by diverting one-half the amount of the dues and the proceeds of the advertising pages. An asset such as we now have in the matter of advertising patronage is not to be lightly thrown away. When the organ was first published, at least one-half of its advertisements were given by local institutions, such advertising being really nothing but what is termed complimentary, contributed for the purpose of helping out a local organization with no expectation of receiving returns. No publication can, however, expect to hold for any time advertising of this kind. A glance through our advertising pages today will show that they are practically filled by national advertisers, advertisers who fur-

nish copy only just as long as they feel it pays to do so. Nothing complimentary is to be expected from this class of advertisers, the proposition simply being one of "We help you as long as you help us." It necessarily takes time to build up a clientele of this sort and the building process is a never-ending one, construction being continuous. With the suspension of a publication, however, even for a few months, the foundation of this construction is given a hard blow. We therefore own an asset in our advertising clientele that should be carefully conserved.

When the present management took hold of THE JOURNAL, as stated above, the membership of the Association was less than four hundred. It was the aim to bring this membership up to one thousand within four years. The State at that time was credited with a medical population of twelve hundred, and it is firmly believed that this aim would have been accomplished by next year if it had not been for the unusual conditions created in the State as a result of the war. We are now credited with a medical population of 1,321. If we can keep our present foundation from crumbling, and our present construction from tottering, there is no reason why, upon our return to normal conditions at the end of the war, we should not build up a strong organization with a membership of from one thousand to twelve hundred members. We believe that the strongest and most effective weapon we have, to prevent our organization from disruption, to be THE JOURNAL. What is necessary to be done to maintain the efficiency of the publication?

In the first place for a medical publication to be successful it must be popular among

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IT IS NOT NECESSARY TO FORWARD YOUR APPLICATION BLANK FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY, TO THE SURGEON GENERAL. PRESENT IT, TOGETHER WITH THE OTHER PAPERS REQUIRED BY REGULATIONS, TO THE EXAMINING BOARD AT THE TIME YOU APPEAR FOR EXAMINATION.



APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

.....  
....., 191.....  
To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.  
Sir:

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....  
.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....  
.....
4. When and where were you naturalized? (For applicants of alien birth only.).....  
.....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....  
.....
10. If either parent or brother or sister has died, state cause and age in each case:.....  
.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....  
.....  
.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc.:.....  
.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates: .....  
.....  
.....
16. With what ancient or modern languages or branches of science are you acquainted?.....  
.....

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\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.

17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result : \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION  
FOR APPOINTMENT IN  
THE MEDICAL RESERVE  
CORPS, U. S. ARMY.

.....Inclosures.

its subscribers, to be popular it must be attractive and interesting, and to have these qualities the first requisite is furnishing original articles of timely scientific interest. Many of our readers will receive their copies of *THE JOURNAL* "Somewhere in France" (or Germany—hic). They will be having experiences of vast interest to all of us and we therefore urge that, whenever time from official duties permit, they will endeavor to furnish as much original matter for publication as may be possible. We also urge all County Secretaries to send in copy of papers read before their respective organizations. We know of several instances in which carelessness in the handling of manuscripts by a County Secretary has robbed *THE JOURNAL* of interesting articles.

Our list of collaborators has undergone many changes in the last few months on account of certain members being ordered to active duty with our military forces. The gentlemen who more recently have consented to act in this capacity, and have been added to the staff, include Doctor Frederick Bowen who will cover the field of surgery, Doctor R. H. McGinnis that of medicine, and Doctor B. L. Armes that of bacteriology and pathology. Doctors Bowen and McGinnis are too well known to the medical profession of the State to need any introduction to our readers. Doctor Armes has recently come to us, being connected with the State Board of Health as senior bacteriologist, with station in Jacksonville.

It has always been thought that our "Reviews from Current Literature" have not been the least popular department of *THE JOURNAL*. We take this opportunity to express appreciation of the untiring devotion and energy displayed by those collaborators who have been compelled to retire from this department and to urge our present staff not to allow the present disturbing times to affect their energies in maintaining the efficiency that has marked the work of their predecessors.

THE JOURNAL OF THE FLORIDA MEDICAL

ASSOCIATION is the property of the medical profession, to conserve it is required the united support and assistance of each member of the profession. *Verbum sat sapienti.*

G. E. H.

## OUR HONOR ROLL.

In spite of the many additions to Our Honor Roll as published below, it is realized that the list is far from complete. Every effort is being made by *THE JOURNAL* to make this list complete, but it should be realized that with the officers scattered over the entire State and with the large numbers of newly-appointed officers being ordered to active duty, the task is not an easy one and requires the cooperation of every member in the organization. The list is supplemented this month by a list, published elsewhere, of all Florida physicians recommended by the Surgeon General of the Army for commissions in the Medical Reserve Corps. In justice and fairness to our confrères that are making sacrifices in entering the services, we bespeak the cooperation of every physician in the State in making this list as complete as possible as early as possible:

### MEDICAL OFFICERS RESERVE CORPS.

#### *Home Address.*

Major Raymond C. Turek.....	Jacksonville
Captain Frederick G. Barfield .....	Jacksonville
Captain E. G. Birge .....	Jacksonville
Captain H. O. Black .....	Jacksonville
Captain Andrew R. Bond.....	Tampa
Captain Henry Hanson .....	Jacksonville
Captain H. H. Harris.....	Jacksonville
Captain Graham E. Henson .....	Jacksonville
Captain Frederick E. Jenkins.....	Palatka
Captain S. M. R. Kennedy.....	Pensacola
Captain Frank R. Maura.....	Ojus
Captain Harry Peyton .....	Jacksonville
Captain M. B. Swift .....	Orlando
Captain Harry F. Watt .....	Ocala
1st Lieut. A. E. Acker.....	Jacksonville
1st Lieut. C. A. Andrews.....	Tampa
1st Lieut. Everard Blackshear.....	Citra
1st Lieut. Louis B. Bouchelle.....	New Smyrna
1st Lieut. John E. Boyd.....	Jacksonville
1st Lieut. Percy H. Brigham .....	Branford
1st Lieut. T. Z. Cason.....	Jacksonville
1st Lieut. Henry B. Cordes.....	Jacksonville
1st Lieut. T. G. Croft .....	Jacksonville
1st Lieut. James S. Davidson.....	Clearwater
1st Lieut. Lester J. Efrid .....	Tampa



1st Lieut. William T. Elmore.....	Gainesville
1st Lieut. Stanley Erwin .....	Jacksonville
1st Lieut. Orin O. Feaster.....	Mulberry
1st Lieut. Julian Gammon .....	Jacksonville
1st Lieut. H. M. Ginsberg.....	Pensacola
1st Lieut. Paul Goss .....	Mulberry
1st Lieut. O. F. Green.....	Mayo
1st Lieut. John Halliday .....	Tampa
1st Lieut. Drew R. Handley.....	Jacksonville
1st Lieut. Maurice E. Heck.....	St. Augustine
1st Lieut. Frank P. Hixon.....	Pensacola
1st Lieut. H. F. Horne.....	Jacksonville
1st Lieut. Roy Howe .....	Daytona
1st Lieut. A. L. Izlar.....	Ocala
1st Lieut. Edward Jelks.....	Jacksonville
1st Lieut. Charles L. Jennings.....	Jacksonville
1st Lieut. Alpheus C. Koon.....	Jacksonville
1st Lieut. Richard Leffers.....	Lakeland
1st Lieut. John P. Long.....	Lake City
1st Lieut. John W. McClane.....	Ocala
1st Lieut. William G. McKay.....	Jacksonville
1st Lieut. R. B. McLaws.....	Tampa
1st Lieut. Earle H. McRae.....	Tampa
1st Lieut. H. R. Mills.....	Tampa
1st Lieut. George M. Mitchell.....	Jacksonville
1st Lieut. Joseph A. Mixon.....	Pensacola
1st Lieut. James B. Parramore.....	Jacksonville
1st Lieut. Archie R. Parrott .....	Jacksonville
1st Lieut. Shaler A. Richardson.....	Jacksonville
1st Lieut. George W. Sherouse.....	Campville
1st Lieut. E. E. Strickland.....	Miccosukie
1st Lieut. G. C. Tillman.....	Gainesville
1st Lieut. B. L. Whitten.....	Fort Pierce

#### THE NAVY.

Passed Assistant Surgeon W. P. Dey, Jacksonville  
 Assistant Surgeon Thomas S. Field, Jacksonville  
 Passed Assistant Surgeon J. K. Simpson, Jacksonville

#### NATIONAL GUARD OF FLORIDA.

Major Lorin Green..... Jacksonville  
 Major Ralph Green ..... Jacksonville || Major James Livingston..... | Jacksonville |
Captain W. J. Buck .....	Gainesville
1st Lieut. Daniel C. Campbell.....	Marianna
1st Lieut. James B. Griffin.....	St. Augustine
1st Lieut. John R. Hawkins.....	Williston
1st Lieut. Z. V. Johnson.....	Milton
1st Lieut. Lucien B. Mitchell.....	Tampa
1st Lieut. J. M. Mitchell.....	Millville

In addressing these officers through the mails, the address should state the rank and branch of the service, such as John Doe, 1st Lieut. M. O. R. C., or Passed Assistant Surgeon John Doe, and be sent in care of the Surgeon General of the Army or of the Navy, Washington, D. C., as the case may be.

#### INSURING OUR FIGHTING MEN.

The plan of Secretary of the Treasury McAdoo for life and indemnity insurance for the soldiers and sailors of the United States, after discussions by representative insurance men and report on by advisory

committees, has been put in definite form and submitted to President Wilson.

The President's comment was as follows:

"I have examined the enclosed papers very carefully and take pleasure in returning them with my entire approval."

A bill has been introduced in Congress along the lines suggested by the Secretary of the Treasury and approved by the President.

In essentials it is proposed that the government furnish at cost to the soldiers and sailors of the United States life and indemnity insurance.

The main features of the Secretary's plan are that the government shall bear all the cost of the administration of the insurance plan and that no expense of any kind shall be a charge on the funds created by the payment of premiums by the soldiers and sailors. Relieved of overhead charges, eight dollars a year for every thousand dollars insurance will be an adequate charge, under the plan, and this figure will put the maximum insurance of ten thousand dollars within the reach of practically every private soldier or sailor. Insurance in private companies would cost many times this sum for men actually engaged in warfare.

After the war the insurance may be converted into other forms. The insurance is to be payable in installments, is non-assignable and free from the claims of creditors of the insured or of the beneficiary, and is limited to the wife, children and other specified kindred.

If total disability results or disease is contracted in the course of service, the compensation is to be based on percentage of pay, with a minimum, however, of from forty to seventy-five dollars a month according to the size of the family. Partial disabilities are to be computed on a basis of percentages of total disability.

Medical, surgical and hospital treatments, supplies and appliances are to be given. Rehabilitation and re-education of the injured soldiers or sailors, fitting them for

lives of activity and usefulness is part of the plan.

The plan also contemplates free allowances to the families of soldiers and sailors, the government supplementing the sums set aside by the soldiers and sailors out of their wages.

The insurance is not to be a gift of the government but is to be paid for out of the pay of the insured men. The government, however, is to take upon itself the cost of collecting and administering the funds and also the extra hazard caused by the war, the rate of eight dollars per thousand being a normal rate in peace time and an entirely inadequate rate for war risk.

The workmen's compensation laws and the experiences of insurance companies in this country and the laws and experiences of other countries have been studied and used in the preparation of this bill.

Secretary McAdoo emphasizes the justice and rightfulness of such a function of the government by citing the fact that in this war we are not relying upon the volunteer system but are drafting American men and compelling them to undergo danger and, if necessary, make the supreme sacrifice for their country. A higher obligation, he says, therefore rests upon the government not only towards the fighting men but towards those dependent on them and a just, generous and humane government should see to it that so far as is practicable they should be given this protection, not as a matter of mercy or charity but as a matter of right. And that they should enter into the service of their country with the certain knowledge that if death or misfortune comes to them they and their dependents are protected by insurance afforded them by their government as part of the compensation for the service they are rendering their country.

In conclusion Secretary McAdoo points out that while this plan may call for considerable expenditures at present, yet the eventual cost to the government of this plan will be very much less than that which would

result from the adherence to the present pension program of the country, and, further, that the pension system will not provide the same benefits nor cover the subject in the same comprehensive, humane and equitable way.

There is no use to which the funds derived from the sale of Liberty Loan Bonds can be put which will be more cordially approved by the people of the country than to provide this just and deserved protection to the men who are braving all the dangers of this war on land and sea in the service of their country.

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### THE VENEREAL PERIL TO OUR ARMY.

The serious havoc wrought among the armies of Europe by venereal diseases—in fact, among all armies not only those of to-day, but also among those of the past—has only recently been realized. Now it is known that venereal infection is the cause of more sickness among soldiers than any other disease or groups of related diseases. As Colonel Keefer says: "Venereal infections are responsible for an enormous amount of sickness in the army—vastly more than any other cause—and constitute the most important health problem with which we have to deal." This, it must be remembered, relates to the time of peace. Quoting from a special report by Vernon Lyman Kellogg: "Syphilis and the other venereal diseases are a scourge fostered especially by militarism. The Surgeon-General's Office has already worked out a program for the coordination of the activities available for the control of these diseases. The reading of this program, printed in *The Journal* last week, indicates that the importance of the problem has been thoroughly appreciated and that there need be no anxiety in this regard so far as it relates to our Army. In working out this scheme of action, Surgeon-General Gorgas called to his assistance some of the leading specialists on the subject. The program,

especially as it relates to prophylactic measures, necessitates the cooperation of the civilian authorities and especially of the civilian physician. Gonorrhea and syphilis are preventable diseases. Ultimately every case of either of these diseases among the men in the Army, if traced back to its origin, will be found to depend on a similar case in the civilian population. Hence, unless the medical officers in the Army camps have the complete cooperation of civilians located in the communities surrounding the camps, it will be impossible for them to carry out the proper measures for limiting these diseases among troops. Here lies the opportunity for the civilian physician to do his "bit" effectively. He should be prepared to recognize these diseases in their early stages, and to see that the patients under his control are properly informed as to the dangers of transmitting the diseases. The principles for the control of syphilis and gonorrhea are no different from those used to control other infectious diseases. They involve the best possible care and attention to patients and the prevention of the spreading of infection from these patients to other persons in the community. The important points to be emphasized are that the civilian physician should satisfy himself that he is thoroughly capable of making an early diagnosis of these cases according to modern methods of diagnosis, and that he should be ready to cooperate with the Federal and State authorities in whatever efforts may be made to control and suppress this scourge. County societies of the counties in which the cantonments are located should be especially alive to their responsibilities and opportunities.

—*Journal American Medical Association.*

#### FLORIDA PHYSICIANS IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

The following Florida physicians have been recommended by the Surgeon General

of the Army for commissions in the Medical Officers' Reserve Corps:

<i>Name and Home.</i>	<i>Rank.</i>
Frank Fenton Ferris, Apalachicola.....	Captain
Walter Joseph Baker, Alton.....	1st Lieut.
Henry Powell Bevis, Arcadia.....	1st Lieut.
Percy Herbert Brigham, Branford.....	1st Lieut.
Samuel G. Hollingsworth, Bradentown.....	1st Lieut.
Roscoe Conkling Hubbard, Bushnell.....	1st Lieut.
Alex. M. C. Jobson, Bartow.....	1st Lieut.
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### A CRITICAL SITUATION.

The government is raising an immense army of volunteers and conscripts to carry on the war to a successful and, we hope, an early termination.

Every army must be supplied with a personnel of medical officers of adequate number and well trained. While provisions have been made to raise the required number of men for the fighting force, it has been left to members of the medical profession of this country to come forward voluntarily, seeking commissions in the Medical Reserve Corps.

Only a few of the total number required have applied for commissions. This means that unless immediate action is taken by the profession voluntarily, the men in the army now being organized will be without sufficient medical care. Such a condition would be more than critical and dangerous for the success of our army and the cause in which we are enlisted. The medical officer plays a most prominent part not only in keeping the army on its feet and physically fit for fighting but in returning to the ranks a large percentage of those who have been temporarily put out through casualties.

How soon will the medical profession of the United States as a whole wake up and realize that doctors must come forward and volunteer their services to the government?

In civil life, when great casualties occur,

the doctor readily offers his services and usually is the first on the scene to save human life. How much more important is it then that, in this critical situation, he should come forward and offer his valuable aid to preserve not only human lives but the life of the nation itself?

Application blanks for commissions in the Medical Reserve Corps are being printed in many medical journals or will be sent to you by the Surgeon General's office or can be secured from members of the local board of examiners.

If you are not acquainted with such a board, the editor of this journal will be glad to advise you. One-fifth of the active profession of the United States is all that is required to supply the army now being raised. Be a part of the one-fifth.

### CAMOUFLAGE.

Camouflage, as most of our intelligent readers know, is not the name of a Swiss cheese, but of a military measure. It is reminiscent of the little jingle:

Little dabs of powder  
Little specks of paint  
Make the girls' complexions  
Look like what they ain't.

Camouflage has been extensively used in France to make spies and investigators believe that a hidden battery possessed of the power of completely annihilating several regiments of hostile troops is merely an in-offensive arboreal retreat or a part of the surrounding landscape. Used with reverse English it causes an old keg to resemble a trench mortar capable of hurling tons of steel. But camouflage is not wholly confined to the war zone. The word fits so aptly many aspects of our daily life that it will soon be a part of our daily conversation. For instance, when a newspaper says that the death rate among the doctors is higher than that of any other part of the service, some camoufler has been camoufling. When it is announced that the army needs 34,000

additional doctors, that's camouflage. But it's psychic not physical camouflage. Even so it may mislead.—*Journal American Medical Association.*

### VOLUSIA COUNTY PHYSICIANS WILL AID ENLISTED COLLEAGUES.

The physician of Volusia county who volunteers for service has no cause to fear that he will have to build up a new practice when he returns from the war. The county physicians have entered into a gentlemen's agreement to take care of their enlisted colleagues' practice and turn over to them or their family one-third of the customary fees collected. Below follows the resolutions of the medical association:

WHEREAS, The United States is at war with Germany and her Allies; and

WHEREAS, Our country's enemies have demonstrated that they are resourceful and ruthless aggressors who, at the command of an autocratic megalomaniac and his staff of cultured fellow-savages, would spread the blight of Prussianism throughout the world; and

WHEREAS, Our government has issued a call to physicians to volunteer their services in the Medical Department of the Army and Navy during the period of the war to which call many of our fellow-practitioners of medicine and surgery, true to the history and traditions of our profession, have cheerfully responded, thus sacrificing in most instances a practice that has taken many years to build; therefore, be it

*Resolved*, by the Medical Society of Volusia County, Florida:

First—That we recognize and appreciate the patriotism of every member of the Volusia County Medical Society who volunteers for the services of the United States government, and should he be called into active service his colleagues who do his practice shall turn over to him or his family, monthly, through the secretary-treasurer of

this society, one-third of the customary fees collected for such practice during his time of active service to our government, and also remit his annual dues to this society during the same time.

Second—That when the physician who was called to the colors returns to private practice his colleagues will be honor-bound to request his former patients when in need of medical attention to summon him.

Third—That a copy of these resolutions be spread upon the minutes of this society, and a copy given to the press for publication.

DR. WM. C. CHOWNING,

DR. R. R. NIBLACK,

DR. H. K. DUBOIS,

DR. DAVIS FORSTER,

DR. C. C. BOHANNON,

DR. J. E. MCGUNAGLE,

DR. JOHN MACDIARMID,

DR. G. A. DAVIS,

DR. J. W. STEPHENS,

DR. L. C. INGRAM, Sec.-Treas.

### AMERICAN WOMEN'S HOSPITALS.

The War Service Committee of the Medical Women's National Association has organized the American Women's Hospitals for work at home and abroad. The Surgeon General of the Army and the General Director of the Department of Military Relief of the American Red Cross have approved the provision made for service to the army and to the civil population. The work will be officially part of the medical and surgical service of the American Red Cross.

The scope of the plan is a broad one. It includes units for maternity service and village practice in the devastated parts of the Allies' countries and hospitals run by women for service there as well as for the United States army in Europe. In this country acute and convalescent cases will be treated in hospitals equipped for the purpose; soldiers' dependents will be cared for, interned alien enemies will be given medical aid and substitutes will be provided to look after the



hospital service and the private practice of physicians who have gone to the front. The first units hope to go to France and to Serbia in the early fall.

Headquarters have been established at 637 Madison avenue, New York City. Dr. Rosalie Slaughter Morton is chairman of the War Service Committee.

---

### THE MEDICAL PROFESSION OF AMERICA MUST SUPPLY ITS QUOTA OF DOCTORS FOR ARMY.

In round numbers, there are about 150,000 physicians listed in our medical directories. Deducting from this number 50,000 names of those who are not in practice or are physically incompetent, there are 100,000 doctors that should be available. Of this number the Surgeon General's office requires 20,000, or one-fifth of the active practitioners, as officers in the Medical Reserve Corps of the United States Army.

The unfounded and possibly maliciously circulated reports of the casualties among the medical profession in the Armies abroad have deterred many from applying for commissions. In reality the number killed on the entire Western front from the beginning of the war to June 27, 1917, a matter of three years, was 195.

The lowest commission offered a doctor is first lieutenant which draws in pay \$2,000 a year; captains receive \$2,400 and majors \$3,000. The cost of equipment is about \$150 to \$175, according to the desires of the in-

dividual. As in civil life, some of us are satisfied with a \$25 suit of clothes, while others pay \$50, and this applies to a medical officer in purchasing his outfit in the way of uniforms, blankets, etc.

The individual outlay when once in the service is principally your expenditure for food, or mess as it is called in military circles, and this will average about \$25 a month, or about \$300 a year, meaning that a first lieutenant should have at the end of the year, or to send home to his family or bank, about \$1,700, a captain about \$2,000 and a major at least \$2,500.

While this information is of interest to those contemplating applying for commissions in the Medical Reserve Corps, the fact remains that in America we have more than a sufficient number of doctors to adequately supply the demand of the Surgeon General's office without hardship to the civilian population.

The need of doctors is not alone for the mobile army but also in concentration camps, evacuation hospitals, base hospitals and on transports. It is of decided advantage to volunteer your services and receive the benefit of the very necessary training accorded physicians in medical training camps. It is a safe assumption that for those who receive such training and show their aptitude for the service, advancement will be rapid.

Applications for commissions in the Medical Reserve Corps will be found printed in medical journals or will be sent to you by your local examining board or by the editor of this Journal. Apply for your commission now. *Your country needs you.*

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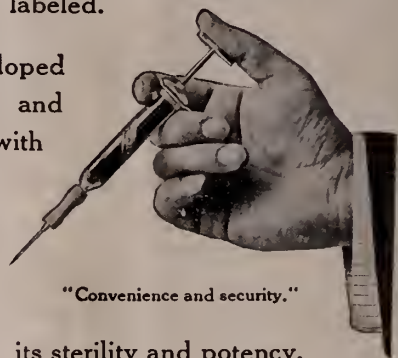
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VOLUME IV      St. Augustine and Jacksonville, Fla., October, 1917      Yearly Subscription, \$1.50  
No. 4      Single Copy, 15c.

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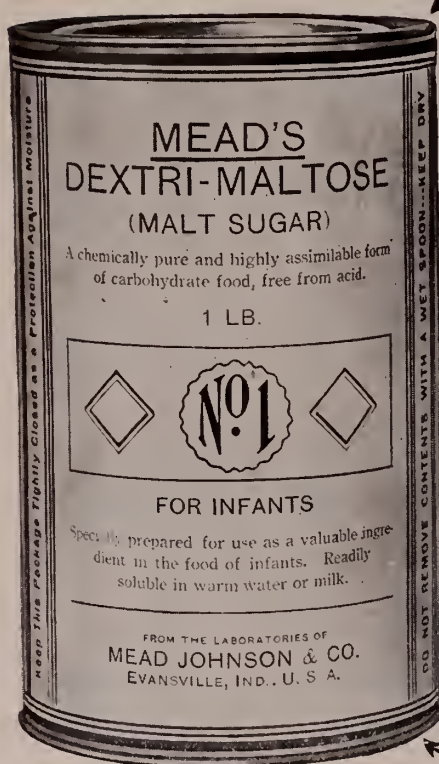
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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, October, 1917

Number 4

## ORIGINAL ARTICLES

### CREEPING ERUPTION.\*

J. L. KIRBY-SMITH, M. D.,  
Jacksonville, Fla.

Stelwagon in his latest text, "Diseases of the Skin," has this to say in regard to the subject: "Creeping eruption (Lee), also larva migrans (Croker), hyponomoderma (Kaposi), and dermatomyiasis linearis aestrosa (Kumberg), is a curious malady, first described by Lee, Croker, and subsequently by others. It has the peculiar feature of traversing the surface, as the name signifies. The furrow made by the parasite is one-eighth to one-sixth of an inch in diameter; just perceptibly raised in the extending part and of a pale rose-pink or reddish color. In the part less recently traversed the line is thin, elevated, more or less continuous, has broken or bead-like linear vesicle. This, in the still older part, dries into a thin crust. Sometimes the whole line is merely a slightly raised erythematous thread-like formation, most pronounced at its extending part, and fading away at the older traversed part. The parasite travels at the rate of a fraction of an inch to several inches daily and seems more active at night." With this preface from the well-known dermatologist, Dr. Stelwagon, I will proceed to my report. For several years the writer has given considerable attention and study to larva migrans infection. In the early part of October, 1914, the attention of the Duval County Medical Society was called to the prevalence in Florida of this interesting dermatosis. A very extensive case was exhibited before the society, one of the accompanying photographs, No. 1, being of this case. Even at that time the frequency

of the occurrence of creeping eruption was emphasized, mention being made of thirty well-developed cases seen in the space of two years of private practice. I might say without exaggeration that since 1914, that is two summers, creeping eruption has constituted 80 per cent of skin lesions seen by me in young people during the summer months, or fall, if the rainy season has been prolonged. Case histories recorded from dispensary and private practice in my seven years of practice in Florida number 210 cases.

At the annual meeting, 1915, of the Florida Medical Association, held at Arcadia, Dr. T. A. Neal, of Sanford, in a paper, "The Chigger in Creeping Eruption," called your attention to the larva migrans. Dr. H. C. Dozier, of Ocala, in October, 1914, presented a very interesting account of creeping eruption in a paper read before a meeting of Seaboard Air Line Surgeons. You will see from these efforts that the seeming insignificance in the occurrence of larva migrans is not justified, as you are lead to believe after consulting the reports of our Northern colleagues. An authority like Stelwagon, of Philadelphia, has seen only a few cases of creeping eruption in an extensive practice of a number of years. In any standard textbook on Practice, Skin or Tropical Diseases, you will find merely a brief consideration of the subject, with an appended bibliography, mentioning varied parasites as a possible cause of creeping eruption lesions of the skin. Outside of the reports of our Florida observers, I can find only four other Southern medical men who have called the attention of the profession to the disease. Dr. Marcus Hasse, in 1910, reported a case in the *Journal of Cutaneous*

\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.



*Diseases.* Dr. Shelmire, of Dallas, Texas, reported a case in 1905. Dr. Moorhead, of Galveston, Texas, in 1906, reported five cases of creeping eruption and mentioned freezing as a therapeutic measure of success. Dr. Hutchins in the same year reports two cases. The writer has had correspondence with Dr. Isadore Dyer, of New Orleans, in regard to a method of recovering the larva in creeping eruption. The disease is evidently not prevalent in the locality of New Orleans, as Dr. Dyer has not had an opportunity of studying the disease to any extent. A few months ago Dr. Howard Fox, of New York City, inquired of the writer how to treat creeping eruption. Dr. Fox wrote that he had recently had his first opportunity of seeing larva migrans. Several cases of the disease had been seen among the New York national guardsmen who had recently returned from the Texas border. These troops had been stationed along the Rio Grande river. I am sure all of you have seen cases of creeping eruption. I would like to be informed at this meeting as to why our attention to this disease has not been called until recent years. Are the writer and other Florida practitioners discovering a new disease for our Land of Flowers? Or is it that we have an old one by a new name with a vivid description appended?

After hearing the ensuing account of creeping eruption, some of you, I trust, will have something to say on the subject, especially from the point of view of the entomology of the parasite. Truly, any information is valuable.

A number of insects have been reported as productive of skin diseases. Mention of a few would not be amiss: the *acarus scabiei*, the pediculi, both the body, scalp and pubic ants, caterpillars, none of these insects producing a larva. I think it is the fly family variety, fleas, ticks, bedbugs, mosquitoes, ants, caterpillars, etc. Among these and other common insects are a few that reproduce by a larval stage. I think it is the fly that is the best known insect that reproduces

itself by the larval stage, and there are any number of species of flies, some being peculiar to certain countries. I fear it is out of place to attempt to play the entomologist. A number of animal parasites have been reported as having invaded the skin of man producing a larva with an accompanying clinical condition; the *Dracunculus* or guinea-worm, the botfly larva, the *echinococcus*, are all known and have been described by medical men. It is generally conceded that the larva of a certain fly, possibly the *gastrophilus*, is the cause of creeping eruption. This, though, is far from being proven, and until the entomologist has taken a hand the exact etiology of this disease will be wanting. A knowledge of the various insects is lacking with the writer, and it is difficult to find one to whom you may turn for information. This state of affairs makes it doubly difficult to offer suggestions for the destruction of the parasite or prophylactic measures tending towards reducing the occurrence of the disease.

It has been suggested that the botfly was causative of creeping eruption, also the chigger; the writer has seen in Mexico a number of botfly boils and chigger infection of the feet and it is hard to see where any resemblance between these lesions and creeping eruption exists. The horsefly is mentioned as a possible source of the larva of creeping eruption. Certainly the home of this fly is not limited to Florida or other low coastal countries. The writer has a personal knowledge of the horsefly in the mountains of Tennessee, and creeping eruption has not made its appearance in that locality.

A larva has been obtained from creeping lesions by the writer on three occasions. Dr. Henry Hanson, late of the State Laboratory, recovered the larva a number of times and we both agree as to the findings. I will append Dr. Hanson's report. I think these results are of interest only for the fact that they will definitely and conclusively settle the disease as being due to a larva of a definite appearance. As to the particular kind

of insect which is responsible for this larva we will have to turn to the entomologist. I am sure you have noticed on the leaves of certain plants or vegetables, for instance the leaves of the nasturtium or the leaves of the cabbage plant, tortuous or sinuous white lines or furrows. Later there appears from these furrows a small worm which has developed from a minute larva that was deposited on the leaves. I have no idea as to the identity of this parasite, but the resemblance to the lesions of creeping eruption is quite marked. Dr. J. H. Rille, professor of dermatology at the University of Leipzig, recently sent the writer a very complete article on creeping eruption, this dermatologist having had an opportunity to study several cases of larva migrans and having successfully recovered the larva. Dr. Rille is of the opinion that a fly of the *gastrophilus* variety is productive of creeping eruption lesions in man.

The disease is no doubt only prevalent in this country in those sections of the Southern States which are near large bodies of water, or swampy regions, especially the Gulf and South Atlantic States. In Florida a trip to the seashore is often the origin of a case of creeping eruption, a tramp through wet grass near an inland lake. A patient who tells of getting out of his automobile in swamp water to crank his car, had the following day a number of very active creeping eruptions on the toes and feet.

In the mountains of Tennessee, the writer is familiar with the various parasitic skin diseases that exist there and no evidence is obtainable of creeping eruption. Horseflies there are, and plentifully too. Uncinariasis is the most frequently met with condition in most of the mountain sections; these two conditions to my mind would exclude any possible connection between the horsefly and creeping eruption, and then again any doubt as to the cutaneous aspect of hookworm being confused with the disease under discussion. Nevertheless, the question as to whether uncinariasis and larva

migrans are one and the same condition has been considered by a number of medical men. The writer has to confess a complete ignorance, from a clinical point, of any knowledge of the character of "ground itch." If I were asked today to describe a case of ground itch I would have to be excused. Patients time and again have consulted me regarding what they considered ground itch. On examination, an eczema,



Fig. 1—Showing active lesion on flank.

dysidrosis, or ringworm infection was found. These conditions all itch, and being on the feet the patient naturally calls them ground itch. I would certainly like to see a genuine ground itch. You cannot find an accurate description of this disease in textbooks. Experimentally uncinariasis is said to have been produced by rubbing on the skin a solution containing the ova of the uncinaria. It is a clear cut vesicular dermatitis, somewhat similar to that produced by the rhus poison. Before it is overlooked, I wish to state that the writer has had examined the stools of a

number of patients with creeping eruption and no intestinal ova were found. It is the writer's opinion that the ova of the uncinariæ gain admission to the intestinal tract through the mouth direct, by uncooked food, etc. The prevalent theory is unscientific and certainly not definitely proven. In most cases of creeping eruption you will find a definite history of the patients having been in contact with wet grass, or sand, or swamp water. The season of the year in which the disease is seen is our rainy season, usually from May until November, or the occurrence of the frost weather. Ordinarily the disease begins at the site of an abrasion in the skin, but in quite a number of cases the larvæ no doubt pass into the skin through the distended sweat coils or hair follicles, it being noted that patients were hot and "sweaty" when they come into contact with wet grass, etc.

It is not probable that there is more than one larva in the individual creeping lesion, nor is it conceivable that the larva has the function of reproduction in its wandering in the skin. The life and extent of some creeping eruption lesions might easily lead one to think that there is more than one larva present in the furrow. Certainly, after treating unsuccessfully a lesion for several months, and apparently having destroyed the larva, and then to have it resume its wandering, possibly just at the site of its last stop, makes one at times think that the lesion is like the cat with forty-nine lives. The solution of this question is to institute your appropriate treatment considerably beyond the point at which you think the larva is resting, and you will invariably produce permanent results. From accompanying photographs you will see that the patients have considerably more than one active creeping lesion, there being no limit to the number of individual infections—from one to several hundred have been counted. The furrows of the creeping eruption lesion are readily seen with the naked eye, at the beginning of the creeping feature

the lesion is very slight and just perceptibly raised above the skin. As the days pass the larva increases in size, the resulting furrow following the wandering of the parasite naturally increases in size and extent. The first few days the larva may only pass over half an inch of space, while at a later day several inches to nearly a foot have been observed by the writer to have been covered during one night by the rapidly-growing larva. One could nearly observe the move-



Fig. 2—Extensive infection of shoulder and back. ment of the parasite, and the patient will tell you emphatically that he can feel every turn in the boring movements of the larva. It is readily seen to what extent the patient will suffer with a number of parasites actively creeping around in the skin. I have not observed any febrile or toxic condition in any of my extensive cases, but loss of weight to the extent of twenty-five pounds was experienced in one patient, this being attributed to the sleepless nights and nervous strain. The writer has had one case in which four months was the duration of the various creeping lesions. In this case



new lesions would appear, and old ones, ineffectively treated, would appear active after a day of quiescence. This patient nearly lost his mind from the attending worry, suffering and loss of sleep.

The degree of thickness of the epidermis over the furrows of the creeping lesions depends on the location of the infection. On the covered parts of the body the furrow is quite superficial and is easily ruptured by the scratching of the patient, while in the palm of hand or the soles of the feet the lesion is more deeply situated and can not be destroyed by the scratching of the sufferer. The larva makes its track in the

appearance of well-developed pustulo derma, an impetigo, this condition being well illustrated in the accompanying photographs. Scarring is rarely a result.

The larva is seldom ever obtained in the pus from the lesions; you will have to look for the larva in the clear serum obtained in the furrow and at the end of or some fraction of an inch from the termination of the furrow. Generally the larva is at rest in the slightly elevated erythematous papule observed at the end of the furrow. With the naked eye, or even with a high-power hand magnifying glass, it is not likely that you will find a larva. In the large and older lesions, with the latter it might be possible. The writer has spent many an hour with the low-power lens examining serum and pus for the larva, and what appears to be a very easy matter is found to be difficult. A failure to find anything suggestive of a parasite is usually the rule.

Photograph No. 2 is of a very interesting case; this young boy was wrestling with a playmate, on the grass near the sidewalk, in the heart of the city. The grass was wet from a recent shower, and this patient noted the beginning of the lesions the following night, the back and shoulders being covered with active lesions; an undershirt and top shirt were both worn by the boy. The scalp, face, neck, arms, legs, trunk, fingers and toes were the sites of numerous creeping eruption lesions. Previously mentioned, exposed parts of the body are more often the site of lesions. Naturally children are more often patients, the hands and feet being the most common site. Generally there are only one or two creeping eruption lesions present, the extensive cases being very exceptional. The writer has seen active lesions in the skin of the eyelid, in the skin of the prepuce of the penis, in the scalp, on the breast of women, any number of cases of the perineal region of children, even extending to the anus. Lesions in this locality with pinworms existing at the same time gave the writer some grounds to consider the in-



Fig. 3—Lesions of Larva Migrans on trunk.

epidermis only, that is, it has not been observed by the writer in any other structure of the skin. At the site of the beginning of a creeping eruption, one will note a small, slightly erythematous papule, somewhat like the lesion of papular urticaria, or a fresh mosquito bite; from this point a few hours or several days may elapse before the larva will begin to migrate. At first the creeping lesion is an erythematous line. Serum fills the furrow, this serum remaining clear unless the epidermis is broken; then the furrow will rapidly fill with pus, and as healing takes place in the old furrow, crusting results. At times the skin will have the

testinal worms as being causative of the creeping lesions.

Time or space in this paper will not permit my giving any data in individual cases. The four accompanying photographs are well illustrative of extensive infections, at least three of them are. It was my intention to present the histories of twenty cases with an account of the various successful and unsuccessful therapeutic measures used to cope with the disease; instead only a superficial consideration of treatment will be given.



Fig. 4—Individual furrow Larva Migrans.

The idea in view when beginning treatment is to destroy the larva at one sitting. When the patient is a struggling child, which is the usual case, this is difficult to attain. First of all, most reliance should be put on a sharp scalpel. With the belly of the knife, rapidly shave off the epidermis over the end of the furrow and to some extent the nearby skin; this can be done with very little pain. Immediately apply a mixture of equal parts of the tincture of iodine and phenol. The next measure to consider

from the writer's experience is to freeze thoroughly with carbon-dioxide snow the creeping lesion. This is easily done, but the ensuing blister is apt to become infected and it is some time before the parts are well. This measure is not so applicable to lesions on the feet. The high frequency annodes is at times the most satisfactory measure, but again in children this is hard to carry out, and is not so certain as the knife. Quite a number of caustics have been used, nitrate of silver, nitric and carbolic acid, applied directly to the furrow and painted around the extending lesion, but these measures can not be relied upon. Injections with a small hypodermic needle of various chemicals have been tried, among them chloroform, tr. iodine, formalin. It is a very difficult and impractical procedure with a struggling child.

Keratolytic pastes and solutions have been tried with indifferent success, same with strong irritating solutions of bichloride of mercury. The best palliative measure is the ice bag or ice-cold water, with parts so treated that for a few minutes the patient will have a short respite from the continual intense itching present. During the day there is very little activity of the larva, especially is this true of the lesions on the exposed parts.

#### THE MANAGEMENT OF INCREASED BLOOD PRESSURE.\*

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In taking up the management of increased blood pressure I shall set forth certain propositions and endeavor to support them by the evidence of cases which have been under observation anywhere from a few months to five years.

1. Disturbances of blood pressure, either in the nature of an increase or decrease from the normal are quite common, and these

\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.

disturbances are usually associated with symptoms which call for treatment.

2. In any given case of increased blood pressure, it is well to determine the average level for that individual and to try to keep the pressure at this point. It is not good practice to reduce an increased pressure unduly, and a drop in the pressure is not always a good sign.

3. Vasodilators are seldom required in the management of high pressure cases and do no permanent good. They are of service, I believe, only in the treatment of angina pectoris. Whatever they accomplish in reducing high blood pressure may be much better accomplished in some other way. Vasodilators may in fact do harm, as in case 35, series A, which when first seen, after having taken nitroglycerin for some time, exhibited dyspnoea as the principal symptom, along with a laboring heart and moderate cyanosis. The blood pressure, as the patient remarked, in a satisfied way, had by this means been reduced to 150. By substituting digitalis for the nitroglycerin, steadying the heart and getting the pressure back up where it belonged, a marked improvement was brought about both in subjective symptoms and objective findings.

4. Increased blood pressure may be reduced and a fair margin of safety obtained in a satisfactory proportion of cases by careful diet, good elimination and moderate exercise.

5. The diet must be moderate and should be non-nitrogenous. Some good authorities permit meats, but my cases seem to do better without it. Tea and coffee are to be avoided, as well as alcohol and acids.

6. Elimination is of the first importance. More can be accomplished in this way than in any other, and neglect of it is responsible for a good many increased pressures. It is best accomplished through the bowel by the regular use of salines, and of these the best is magnesium sulphate. By regular, I mean daily if necessary. To reduce a pressure

quickly I have found nothing so useful as calomel followed by magnesium sulphate.

7. Moderate exercise is of the greatest advantage in treating high pressure cases. A good many of the patients are stout and unaccustomed to walking. Others have had their activities restrained either through fear or by instruction. I find practically all cases helped by short walks gradually increased and taken daily.

In given cases rest may be absolutely indicated and rest in bed is one of the surest ways of bringing down an unduly high pressure.

8. Blood pressure should be taken with the sphygmomanometer and the reading made with the stethoscope. Some men endeavor to estimate blood pressure by simply feeling the pulse. It can not be done successfully! The aneroid instrument, in common use today, is easy to operate and quite satisfactory.

9. Digitalis and strychnia, in ordinary therapeutic dose, do not raise blood pressure. If the pressure is below its normal average, it may be restored to its proper level by the use of these remedies. There is no contra-indication to their use in increased blood pressure per se. If the patient's symptoms require the use of either remedy, it should be administered without fear. Practically all cases of high pressure will sooner or later show evidence of cardiac decompensation and the symptoms of this condition absolutely indicate the use of digitalis.

In this connection it is well to point out again that these cases exhibit a drop in pressure, which is an unfavorable symptom. Pressure readings made only in this stage of broken compensation may be entirely misleading. Improvement in these cases is accompanied by a restoration of blood pressure to its normal level. Strychnia is of greatest service in lowered blood pressures, but is also of advantage from time to time in toning up the high cases.

10. In the prognosis of blood pressure it is well to remember that women stand in-



creased pressure very much better than men. It is well also to remember that arteriosclerosis and increased blood pressures are more or less natural phenomena associated with advancing years and that the increased pressures, in themselves, are not necessarily of bad prognosis.

The uneasiness of the laity over increased blood pressures is but a reflection of the uneasiness in the mind of the profession. We have not yet as a whole learned the real significance of blood pressure. Some men even think it best to keep patients in ignorance of the blood pressure readings, because if told they will worry over them. To me it seems best in this regard, as in all others, to deal frankly with the patients. The physician is certainly not responsible for the arterial changes and the patient who has an intelligent understanding of his condition will be the more willing to carry out the orders necessary for his improvement.

It is most enlightening to watch some patient, with pressure well over what we consider the danger line, go on for years without anything happening.

*Case 26 B* was first seen July, 1912, with a systolic pressure of 240, age 62. She has been under observation ever since that time and so far has escaped anything worse than mild decompensation.

*Case 15 B* had a systolic pressure of 265 on March 4, 1914. This patient did have cerebral hemorrhage and died from it, but not until April 8, 1916, age 56.

*Case 31 B*, a colored woman of 67, had on March 21, 1916, a pressure of 270-155. Three days later the reading was 250-145. Nothing has happened to her up to May 17, 1917. It will help very materially if the physician points out to his patients that cases of increased pressure which come under treatment and carry out the regime, do not often come to grief.

11. Angina pectoris may be associated with a low blood pressure. In a series of six cases the blood pressure was over 200 in only one. This case, 7 B, age 48, has had angina for two years.

*Case 36 A*, with angina beginning in February, 1915, has had a pressure ranging from 135-75 to 166-110, age 48.

*Case 9 A* has had a pressure of 155-90, age 74, died of cerebral hemorrhage.

*Mrs. W.*, age 37, seen May, 1915, has had angina for five years. Her pressure was 112-72.

*J. L. P.*, male, age 50, who has suffered from digestive distress for two to three years, died suddenly in 1916 before any one could reach him. He had very severe pain and probably died of angina. His systolic blood pressure had been 85.

*G. C. M.*, male, age 51, under observation from December, 1915, to March, 1916, and treated for gastrointestinal symptoms, had a systolic blood pressure of 100. He died at his desk one morning and autopsy demonstrated coronary arteries that were pipe stems.

12. Blood pressure readings should be made periodically throughout pregnancy as a routine procedure just as the urine is examined. An increased or rising pressure gives the signal of threatened eclampsia.

A few weeks ago I saw a young woman at the end of her first pregnancy who said she felt perfectly well and exhibited only a slight swelling of ankles and legs. She had a marked albuminuria at that time, but this had come on within the week, so the attending physician stated. No blood pressure readings had been made. When the pressure was taken a reading of 200-125 showed clearly that the patient was sitting on the edge of a volcano. Labor was induced forthwith and the case successfully terminated.

In conclusion, and in support of some of the statements made in this paper, I am submitting statistics from 67 cases on which I have fairly good data:

SERIES A. 36 CASES.			
Systolic Pressure from 150 to 200.			
<i>Men.</i>		<i>Women.</i>	
17		19	
<i>Apoplexy.</i>			
4 cases, 23.53%		1 case, 5.26%	
<i>Uraemia.</i>			
2 cases, 11.76%		3 cases, 15.78%	

*Cardiac.*

Decompensation,	Decompensation,
6 cases, 35.29%	6 cases, 31.57%
Angina, 1 case 5.88%	Angina, 1 case, 5.26%
Pericarditis .....none	Pericarditis,
	2 cases, 10.52%

*Death from any cause.*

6 cases, 35.29%	4 cases, 21%
Cerebral softening... 1	Uræmia ..... 2
Heart ..... 1	Cancer ..... 2
Cancer ..... 1	
Uræmia ..... 1	
Apoplexy ..... 2	

*Under observation.*

1 year or less..... 9	1 year or less..... 9
1 to 2 years..... 6	1 to 2 years..... 7
4 years ..... 1	2 to 3 years..... 3
5 years ..... 1	

## SERIES B. 31 CASES.

Systolic blood pressure over 200.

<i>Men.</i>	<i>Women.</i>
4 cases.	27 cases.
<i>Apoplexy.</i>	3 cases, 11.11%
None.	<i>Uraemia.</i>
1 case, 25%	3 cases, 11.11%

*Cardiac.*

Decompensation,	Decompensation,
1 case, 25%	5 cases, 18.51%
Angina .....none	Angina ..... 1 case
Pericarditis .....none	Pericarditis ... 3 cases

*Death from any cause.*

Uræmia ...1 case, 25%	5 cases, 18.51%
	Uræmia ..... 3 cases
	Heart ..... 1 case
	Apoplexy ..... 1 case

*Under observation.*

1 year or less..... 2	1 year or less.....14
1 to 2 years..... 1	1 to 2 years..... 6
2 to 3 years... .. 1	2 to 4 years..... 5
	5 years ..... 2

## A FEW POINTS IN THE TREATMENT OF CHRONIC GONORRHEA.\*

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My reason for presenting this subject is on account of the cry of despair we so often hear as to whether this condition, chronic gonorrhea, can really be cured. Not only from the patient but often from the general practitioner as well do we hear this, and no doubt you have at some time or another heard a colleague say, as far as getting therapeutic results are concerned: "I would rather have syphilis than gonorrhea."

Yet in spite of this I will say that these so called incurable cases remain so for a lack

of correct diagnosis, and if we would only take time and look carefully into these cases we would find a cause in each that could be rectified by appropriate treatment.

By careful and intelligent use of the urethroscope and the correct interpretation of the expressed secretion from the various glands that empty their product into the genitourinary tract, I'll venture to say that the focus of infection can be found and otherwise incurable cases can be cleared up by rational treatment.

In ordinary cases of antero-posterior urethritis we can usually get a cure in from six to ten weeks, after which time if we still have a persistency of discharge or morning drop, we will have to look further to locate the cause.

The causes for a chronic gonorrhea are so numerous that I will not attempt to enumerate all of them but just a few of the more common and some that have come under my own observation.

First we examine the topography of the seminal vesicles and prostate, and here very often we find the cause of the persistency of discharge and shreds. By systematic milking of the vesicles, massage of the prostate, not oftener than once every four days, irrigations with a solution of silver nitrate, starting with a 1-16000 solution and gradually increasing the strength to a point of tolerance, we can usually clear up the urine and bring the condition back to normal. It is in this class of cases that we are often able to benefit our patient by the use of bacterins, sera, or vaccines.

Now supposing that we have examined the prostate and vesicles and find them in good condition, we next look for obstructions along the channel of the urethra and here, in over fifty per cent of the cases, we will find our cause, either as a constricting band, soft or hard infiltration.

It is here that I think a seemingly slight defect is often overlooked, at least I have found it so in cases that have been referred to me. I refer to a small meatus, or an ap-

\*Read before the forty-fourth annual meeting of the Florida Medical Association, at Atlantic Beach, May 18, 19, 1917.

parently normal meatus with a post meatal band which will not admit even a number twenty F bougie. There can be no doubt but the constant irritation produced by the sudden checking and damming back of the urine in the urethra causes a persistency which would have cleared up had a meatotomy been performed and a free and unobstructed flow been allowed.

Strictures in a majority of cases will yield to dilatation, but if we have to deal with a hard fibrous resilient one, it is just a waste of time trying to accomplish anything by dilating and the sooner a urethrotomy is performed so much sooner will our patient be cured.

After having made an examination of the prostate and vesicles and having found no involvement nor any constriction or infiltration, we next resort to the invaluable use of the urethroscope which will usually find the cause or focus of infection. In a great many cases we do not see anything pathological except a slightly granular condition of the urethra in certain localities or else areas of chronic inflammation which can only be cured by irrigation and dilatation. On the other hand we occasionally find a polyp, papilloma, ulcer, excessive granulations, a lacunitis or an infected follicle, and then do we feel well repaid for our pains in doing a urethroscopy, for otherwise we have a condition that could not be cured except by direct treatment through the urethroscope.

To illustrate I am going to report one or two cases to show the importance of finding the focus of infection in clearing up these cases:

*Case No. 1. M. H.* Age 24, clerk, contracted gonorrhea two years before. Had been treated for over a year but could not get rid of the morning drop and shreds in the urine. He became discouraged and gave up all treatment for several months. Upon presenting himself to me the following were the findings: First, urine clear with long curled up shreds; second, urine clear with small shreds and debris. Prostate almost

normal in size and consistency, seminal vesicles not palpable. Microscopic examination showed a few leucocytes but could not find any intracellular diplococci. Urethroscopic examination with a Geiringer urethroscope showed plugs of pus attached to the glandular openings on the floor of the prostatic urethra. Anterior urethra showed nearly all the lacunæ of Morgagni were enlarged and were full of plugs of pus. Treatment consisted of irrigations with a nitrate of silver solution every other day, prostate was massaged every fourth day and entire urethra dilated once a week with a Kollman dilator. After six weeks of this treatment the morning drop had disappeared and second urine had cleared up, but the first urine still showed small shreds. Anterior urethroscopic examination showed the lacunæ still covered with plugs of matter. These were then cauterized through the urethroscope once every four days. After the third application the urethra became normal in appearance and shreds disappeared from the urine. This case was rebellious to treatment because of the mild prostatic involvement as well as the lacunitis which had been overlooked.

*A. H. A.* Age 33, salesman, had gonorrhea at 18 years of age, lasted year and a half, and has had several recurrences of discharge for which he had used astringent injections with result of stopping discharge. About 18 months ago noticed discharge and used usual remedies but could not get rid of the morning drop. About six weeks before I saw him commenced to have painful and frequent urination with an occasional terminal hematuria. Was referred to me as a case of cystitis. His urine was clear but contained many shreds. Urethroscopic examination showed an enlarged and very much inflamed colliculus covered with a great many small polypoid vegetations. These were painted with a twenty-per-cent silver nitrate solution once a week and while the reaction after each treatment was quite severe, his condition improved, pain became



less and at the end of a month his urine had become free of shreds and he was apparently normal.

Now this was a case in which it would have been impossible to get any satisfactory results except by direct medication through the urethroscope.

## BATHS IN NEURASTHENIA.

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DeLand, Fla.

Before entering upon the treatment of neurasthenia in any form, it will be proper for me to give an epitome of the most salient features of the disease as we generally see it.

The point has been raised whether it was not proper to call neurasthenia a state, or condition, rather than a disease. It is, however, beyond a doubt, a psycho-neurosis. There is always a neuropathic tendency and that special sort of incompetence of the central nervous system, in consequence of which fatigue occurs with undue readiness, and without apparent cause. There is, of course, a cause, but it is often obscure, and the history you get from your patient is not always "the truth, the whole truth, and nothing but the truth." Bearing this fact in mind, get all you can from your patient, but, before committing yourself to any positive diagnosis, get collateral facts from members of the family or friends, as the case may be.

Neurasthenia is defined as being a functional exhaustion, or debility, of the tissues, especially those of the nervous system, due primarily to impaired metabolism, and secondarily to auto-intoxication.

Arteriosclerosis is also, beyond a doubt, a most common etiological factor.

In addition to the symptom of sudden fatigue mentioned above, we have headache, backache, muscular weakness, mental irritability and insomnia.

There are also sexual and mental phenomena, and a form of nervous indigestion which is very intractable; in fact, it is safe to say that no part of the system, mental, physical, or sexual, is in a normal condition.

This disease may develop at any age, and is often first noticed at or about the age of puberty, is essentially chronic, and in this particular is an exception to the general rule that diseases of the comparatively young are usually acute and functional, while those of the comparatively old are chronic and organic.

Europeans call neurasthenia the "American disease" and give us credit for living too fast, with too much rush and competition.

Wall Street is, no doubt, responsible for the production and perpetuation of a great many neurasthenics, and there are too many Wall Streets.

The English business man, on going to dinner, indicates in the usual way that he will be back in two hours," the average American will say, "Gone to dinner, back in five minutes."

In the treatment of neurasthenia we go back to first principles and try to remove the cause, and we are to remember that we are treating the patient, not the disease; and further that it is the physician, himself, who does the most good for this class of patients, not what he prescribes, and it is indispensable, as a means to this end, that he has the confidence of his patient as well as his cooperation.

I shall not touch on general therapeutic measures, but go back to the title of this paper, "Baths in Neurasthenia."

Neurasthenia is not generally considered to be an acquired disease, but an inherited weakness of the nervous system, and therefore is not, strictly speaking, curable. Undoubted facts, however, show that it is often an acquired disease, and that it is often recovered from. This may sometimes happen on the removal of the cause alone.

Many authors claim that hydrotherapy, by the proper use of baths, is superior to any and all other methods of treatment in this disease. It is, of course, important that we adopt the proper technic in administering them, or we may do more harm than good.

There can be no positive or definite for-

mula as to temperature of water, or form of bath, as no two patients are exactly alike, or in the same condition. But the general principles are these:

The water must be cold, because cold improves the muscular tone of the vessels. In other words, it increases tension—warmth relaxes, causing passive dilatation and loss of tone, although both produce a hyperemia; one is the result of reaction and is tonic, while the other is the result of relaxation and is atonic.

The patient must be warm before the application of the bath, and one or more of the following methods may be used in giving it: Ablution, shower bath, effusion, sheet bath, drip sheet, compresses, wet pack, tub bath and douche.

You are probably all familiar with the technic used in these various forms of baths, the temperature of the water, and the method used must be indicated by the general condition of the patient, always remembering that the bath, of whatever form, must be followed at once by friction or massage. This is often necessary to promote and insure reaction which is, in every case, imperative.

The absence of reaction would indicate that the water had been too cold, or that the application had been too long continued, or given with too much force as in the douche or shower bath, and the result would be that the patient would be chilly too long after, and you might also get a catarrhal inflammation of some of the mucous membranes, and other unpleasant sequela, but with a little personal supervision we can usually find out what form of bath can best be tolerated, and the temperature suited to each individual case.

The results which we gain are mainly through excitation of the nerves of the skin. A powerful reflex stimulation is exerted on the skin and its blood vessels, as well as the muscles and deeper lying organs including the brain and spinal cord.

Beside the vascular effect of the cold bath, the whole muscular system is stimulated, heat production is increased, and respiration is deepened.

Putnam, who has had a large experience with this disease, claims that where the hereditary tendency is absent, and the patient comparatively young, and where there are proper facilities for giving the bath treatment in the proper form and as long as necessary, there is no other form of treatment demanded, and the results are almost invariably satisfactory in every respect.

---

### TINNITUS IN NEURASTHENIA.

FREDERICK J. WALTER, M. D.,  
Daytona, Fla.

Disorders of hearing in neurasthenia are rather consistent with the other phases of the disease. Patients will say they can not "hear right." When investigated this symptom proves to be psychic and not directly referable to the ear—that is, it is due to the lack of power to sustained attention and not to any true difficulty of hearing. There is, however, frequently an auditory hyperesthesia to a marked degree. Patients may suffer exquisitely from noises, even when the latter is insignificant. Secondary auditory symptoms are prominent; this is especially true of tinnitus of which a large number of patients complain.

The above is the observation of Dr. F. X. Dercum, a neurologist of the University of Pennsylvania.

Subjects of neurasthenia often have pulsating noises very pronounced. There will be no pathology discoverable in these cases though at times anemia. Over-mental or physical exertion or grief may produce the same. Neurasthenic patients may complain of most anything, and in deciding whether trouble in the ears is really due to some pathological change or a psychical condition it is many times important. Many neurasthenics do have a real middle ear catarrh. The subject of the cause of tinnitus in gen-

APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.

Sir :

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....
4. When and where were you naturalized? (For applicants of alien birth only.).....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....
10. If either parent or brother or sister has died, state cause and age in each case:.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc.:.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates: .....
16. With what ancient or modern languages or branches of science are you acquainted?.....

\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.



17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result: \* .....
20. Are you a member of any State medical society? If so, give its name:.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service:.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity: .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it:.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....  
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149

W. D., S. G. O.

(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.

eral is as broad as the treatment of diseases of the ear and brain itself and can not be gone into at this time. However, being a symptom of neurasthenia, the prognosis is dependent upon the relief of the neurasthenia.

#### PROPAGANDA FOR REFORM.

**PEPSODENT.**—Wm. J. Gies writes that Pepsodent is a dentifrice widely advertised as a mucin digestant. In a research conducted for the First District Dental Society of the State of New York, Professor Gies and Miss Franke found that the digestive claims were not warranted in any degree. Gies holds that there is about as much common sense in the proposed use of Pepsodent for this purpose as there is in the oral administration of a few grains of Lactopeptine to improve impaired tryptic digestion in the intestines (*Jour. A. M. A.*, April 28, 1917, p. 1278).

**SLEEPY WATER.**—Chicago physicians are told by the Sleepy Water Corporation that Sleepy Water is a "cure" for diabetes, Bright's disease and many other ills. The claim is also made that for six years not a single case of nephritis or diabetes treated with this water has failed to be cured. Sleepy Water sells for a dollar a gallon, but you cannot buy less than fifty gallons. At least a gallon a day must be taken and even five gallons a day may be taken "without any detrimental effect upon the heart action, no matter how bad the heart action seems to be." If we are to take the corporation's word for it, "Sleepy Water" has performed many miracles, although details of its modus operandi are not forthcoming, "as no autopsy has been performed on a person cured by Sleepy Water." (*Jour. A. M. A.*, Nov. 18, 1916, p. 1530.)

**CITRIC ACID AND CITRATES.**—Citric acid and the alkali citrates, potassium citrate and sodium citrate are oxidized in the body with formation of carbonates and hence tend to increase the alkalinity of the blood. Citric acid and the alkali citrates tend to render the urine less acid and, in large doses, ren-

der it alkaline (*Jour. A. M. A.*, April 21, 1917, p. 1206).

**MORE MISBRANDED NOSTRUMS.**—The following "patent medicines" have been found misbranded under the U. S. Food and Drugs Act, chiefly because of unwarranted and false therapeutic claims: Dr. Jones' Liniment was recommended for corns, toothache, backache, "rheumatism" and various other conditions. Analysis showed it to be "essentially a gasoline solution of oleoresin of capsicum, oil of sassafras, methyl salicylate, and evidently, volatile oil of mustard." Graham's Dyspepsia and Heartburn Remedy was found to contain, among other things, sodium bromide, sodium bicarbonate, magnesium carbonate, sugar, chloroform, alcohol and small quantities of morphine. It was asserted to be a remedy for gastritis, ulceration or threatened cancer of the stomach, and all disorders arising from an impaired digestive system. Mother Hart's Baby Syrup admittedly contained opium and alcohol. It was asserted to be "A Safe Remedy for the Home." Dr. Hale's Household Ointment was sold as "A Positive Specific for the Speedy and Permanent Cure of Rheumatism, Lamé Back, Neuralgia" and many other conditions. Analysis showed the ointment to be composed of "vaseline and camphor with a small amount of aromatics resembling oil of thyme." Dr. Greene's Nervura was sold for nervousness, nervous debility, weakness, poor blood, etc. It was found to contain 18 per cent of alcohol, and celery, ginger and other unidentified vegetable material were indicated. Hill's Freckle Lotion was claimed to be absolutely harmless when used externally according to directions. Yet it was found to contain corrosive sublimate. Dr. Hiatt's Germicide was sold as a specific for croup and for diphtheria, quinsy, sore throat, etc. It was a syrup containing sodium benzoate, phenol, alcohol, a small amount of glycerin, probably balsam of tolu and flavored with oil of wintergreen. (*Jour. A. M. A.*, Nov. 25, 1916, p. 1615-16.)

## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville.  
Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association,  
St. Augustine, Florida, or 334 St. James Building,  
Jacksonville, Fla., U. S. A.

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**Next Meeting — Tampa — May, 1918**

## CIVILIAN-PHYSICIAN ASSUMES RE- SPONSIBILITIES OF CARE OF AN IMMENSE ARMY.

There are in the United States today thousands of physicians who with but a few weeks' notice have entirely changed their activities and assumed the care of an immense army about to take the field against an enemy. The transfer of a life devoted to the care of the sick, a life that comes into closer contact with the individual than that of any other vocation where the slight ills and complaints have to receive sympathetic aid, to such a life as the Medico-Military Officer must assume is one of great proportions and a transfer that is not appreciated by the civilian-physician until he becomes a part and parcel of the immense corps that will have the care, in every sense of the word, of our soldiers.

As physicians we have been drilled in the matter of actually caring for the sick, in the matter of diagnosing their ills, and prescribing medication or resorting to surgical intervention when necessary. Outside of the comparative few engaged in public health matters, our work has been confined to these limits.

The duties of the Medical Officer with an army covers vast fields that are but little known by his brother civilian-physician. The care and inspection of foods, the sanitation of the camp, the executive work connected with medical organizations in the field, the drilling of sanitary squads to enable them to properly handle the wounded on the field, the transportation of the wounded, the establishment of dressing stations, field hospitals, and evacuation hospitals, these and numerous other details that make up the duties of the Medical Officer have no place in the life of the civilian-physician. The Surgeon General of the Army in building up a Medical Reserve Corps realized that the civilian-physician, no matter how proficient in medical matters, was not equipped to take up the duties im-



posed upon him by war conditions and therefor organized throughout the country Medical Officers' Training Camps. Newly-appointed officers are given a course of instruction along the lines outlined above and made familiar with their new duties. Some months ago when these camps were first established, newly-appointed officers ordered to report at these camps for courses of instruction in numerous instances made every possible effort to have their orders revoked, taking the position that they did not enter the Medical Reserve Corps "to go into some camp at home" but to actually engage themselves at the front in the care of the wounded. It must be a matter of pride to the Surgeon General of the Army that reports emanating from officers in these training camps have been of such a nature that a decidedly different attitude is now assumed by the officers ordered to these camps for courses of instruction. Where a few weeks ago physicians were praying that they might receive a detail other than to a training camp, they now realize that to be properly equipped for service in the field, and to be in a position to give a good account of themselves, such a course of instruction as is given in a Medical Officers' Training Camp is absolutely essential. We publish in another column of THE JOURNAL a communication from Major John E. Boyd, Medical Reserve Corps, U. S. Army. Major Boyd, who is well known to every physician in Florida, has been stationed at Camp Greenleaf, Fort Oglethorpe, Ga., as an instructor for some months. We urge our readers, especially those contemplating going into the Medical Reserve Corps in the near future, to carefully go over this communication from Major Boyd. By doing so many false impressions will be corrected and the newly-appointed officer will have no feeling of regret when he receives his order assigning him to a course of instruction at this camp.

The training camp serves a double purpose of training officers in the new duties

they are going to have to assume, and acting as a sort of a clearing house in determining the adaptabilities of the various officers. Some men while, in civil life, engaged in one of the special branches of medicine, develop a natural adaptability for some particular line of work to be carried on by a medical officer. The government finds a valuable asset in such a type of officer; an excellent internist may develop into an expert sanitary officer, and as such be of inestimable more value to the nation. There is no question that the creation of the Medical Officers' Training Camps was a most happy one, one that is going to serve its purpose well, one that is going to create efficient medical officers and one that will materially assist the civilian-physician in assuming the responsibilities of the care of an immense army.

G. E. H.

#### OUR HONOR ROLL.

A large number of men have been added to the Honor Roll this month, but we are perfectly aware that the list is still far from complete. THE JOURNAL wishes to take this opportunity to again urge all county society secretaries, in fact all readers, to send in the names of all Florida physicians who to their knowledge have been ordered to the colors, but whose names do not appear in the following list:

#### MEDICAL OFFICERS' RESERVE CORPS.

##### *Home Address.*

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Major Raymond C. Turck .....	Jacksonville
Captain Frederick G. Barfield .....	Jacksonville
Captain E. G. Birge .....	Jacksonville
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#### THE NAVY.

Passed Assistant Surgeon W. P. Dey..... Jacksonville  
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#### THE MEDICAL OFFICER IN TRAINING CAMP.

To further the interest of the Surgeon General's Office in securing a sufficient number of applicants for commission in the Medical Reserve Corps, and at the suggestion of the American Medical Editors' Association, THE JOURNAL addressed a letter to Major John E. Boyd, Medical Reserve Corps, United States Army, stationed at Camp Greenleaf, Medical Officers' Training Camp Fort Oglethorpe, Ga., requesting him to furnish a communication detailing the life of the newly-appointed Medical Officer at the Training Camp. Major Boyd kindly complied and furnished the following communication, which has been approved for publication by the Adjutant of the Camp with the request that copies of THE JOURNAL, containing the communication be furnished the leading medical journals of the country, requesting them to print the communication in their respective columns. It is needless to say that this request will be complied with.

The communication follows:

"1st Battalion Headquarters,  
 "Camp Greenleaf, M. O. T. C.,  
 "Fort Oglethorpe, Ga.,  
 "September 30, 1917.

"To the Editor:

"It is a privilege to detail the workings of the Medical Officers' Training Camp at this place and the cold facts shed a light that would attract any real man.

"The medical man from civil life, after years of close confinement and the petty annoyances of a professional life, steps into the midst of a thousand or more educated men. These men hail from all parts of the country and all have a common interest and purpose—the defense of the honor and glory of their native land.

"These men are all students—all eager to learn the game in its many phases and almost from the start they cast aside the restraints more or less peculiar to civil practice and appear in all the glory of 'the man.'

"The man is assigned to a company and he starts on his new career. He lives in barracks, well ventilated but protected from the bad weather, lighted by electricity and to be heated with stoves. His cot is most comfortable and he still enjoys the luxury of a mattress and clean sheets. He is camping out in plenty. Not the least of the real pleasure is learning how to care for his own bed, bedclothes, personal clothes and his allotted space. Having retired early, he awakes proportionately early the following morning and turns out with all his comrades for the physical training that is going to add years to his life, make him feel that life is worth living and fit him for the real duties to come. In this camp he is especially blessed in the physical director—a man selected from the Medical Reserve Corps ranks and gifted in his special line as few men are. To his wonderful knowledge of exercises best suited to restore the buoyancy of youth, Captain McConaghy adds a wonderful personality which stimulates men to do their best.

"After limbering up, the man cares for his personal needs and then goes to one of the most remarkable assets of the camp—the company mess. A clean, orderly building; clean wooden tables; clean dishes and wonderful food, well cooked and served. He eats with a growing boy's appetite and wonders at the keen relish had for the food.

"Having satisfied the inner man, everybody joins in a general police of ground and barracks. This police means large numbers of men to do a proportionately small amount of work. It's not operating, visiting the sick and suffering, or listening to hard-luck stories—it's doing a little easy work while rubbing elbows and passing pleasantries with your comrades.

"The real military game is now on. You

learn how to stand erect, keep your head up and eyes to the front. You are instilled with the respect and love due your superior officer. You inculcate attention, concentration, accuracy, promptness, co-ordination, independence and the power to command. You become imbued with the military spirit and soon the drill hour is looked forward to and longed for. In place of being the drudgery, that some people think, it is instead life to the last drop and the man fairly drinks in the air and the '*esprit*' that goes with it. He feels himself a bigger and better man; throws up his head; swells out his chest and plants his feet with a firmness and meaning never known to him before. Can anyone dare call this work? 'The individual at home, shut in by his narrow surroundings, should visit a training camp and find the answer to this question in the faces of these wonderful men. There is a glorification that does not require the eye of the artist to see.

"When I see them at drill is when I love them most and I could just stretch out my arms and gather them all in and say: Oh! you wonderful, wonderful Americans!

"Having returned from the morning drill, these men assemble in the great big outdoors and have their duties, obligations, responsibilities, accountabilities and privileges explained to them by patient, wonderful men, experienced in the service. These men come before you with the bigness of simplicity and with an attitude, tone, demeanor and personal equation show you they are your friend. After condensing in intelligent brevity a fund of knowledge gleaned through years of hard work they throw the gates wide open and say to these thousand eager men, 'Now, gentlemen, are there any questions? I am here to help you all I can,' and they answer over and over again in detail the most trivial questions as well as the most leading ones. Is there any attitude of superiority or prudishness about that? I have passed through this training camp and these are cold, undressed facts of



daily occurrence. As busy a man as he is, and he is responsible and accountable for many thousands of men, their teaching and well-being, the Commandant comes out in person and talks to these men in the most wonderfully personal way. There is an absolute absence of superiority or aloofness. You are made to feel that he loves you, watches over you, and stands by and fathers you personally. One of the big privileges and pleasures enjoyed by the men ordered to this camp is the knowing of a real soldier, a great leader and above all *a man*. This man is aided and abetted in his work by Medical Corps men of the same kind and timber. If there are any '*shorts*' in the Medical Corps of the United States Army, the Surgeon General did *not* send any of them to Fort Oglethorpe, Georgia. Such wonderful patience and friendly interest I have never met before.

"I desire to digress a minute and say for the benefit of the doubting Thomases that I spent ten days in a cavalry regiment, clear away from my professional associates. I was treated like a prince by the Colonel and all his officers. I wondered where the idea of snobbishness on the part of these line officers originated. Surely some small individual, with a big head, found himself out of place in an assembly of big men and attempted to cover his shortcomings by barking at the moon.

"After the mid-day meal, the men congregate in groups of twelve to twenty-four and under the leadership of carefully selected men are quizzed and reviewed on the previous day's instruction. All the details of the daily teaching are here clarified and the different blank forms exhibited and fully explained. The Quizz Masters all work under the direct instance of Lieut. Colonel Brooke, Medical Corps, U. S. Army. This officer was selected with great care and is in entire charge of all instruction in this camp. A wonderful student; an inveterate worker; a strict disciplinarian and a real organizer. With the above qualification is

combined a quiet, unassuming personality, a remarkable memory and an inexhaustible patience—a real instructor.

"An hour each day is further set aside for lessons in French. These lessons are robbed of all dryness by the avoidance of technical details and starting right in with the simple phrases of every-day life and the means of moving around independently in a foreign country.

"In addition to the foregoing the men assemble at appointed hours to listen to talks on special medical or military subjects by real specialists. These specialists are drawn from the length and breadth of this enormous camp of which the Medical Training Camp is a small part only. This interesting program is still further enhanced by the big men coming in as visitors. I need only mention such men as Colonel Munson, Medical Corps, U. S. Army; Colonel Goodwin, of the English Army; Colonel Dercle, of the French Army, and Dr. Taylor, Food Specialist on Mr. Hoover's Committee.

"The last duty of the official day and the most inspiring in this camp, and all camps in this great big beautiful country, is the blessed privilege of paying tribute to the National Emblem. No man with human instincts and a soul can resist being stirred to every atom of his body when quietness reigns supreme; everybody stands erectly and respectfully still; all nearby work ceases; the band plays 'The National Anthem' or the bugle sounds 'To the Colors'; the great and glorious flag, emblem of all this Nation reveres and stands for, is slowly and respectfully lowered, no part *ever* being allowed to touch the ground and all soldiers face the flag and renew their allegiance to the land of their birth or adoption. Is this work? Is it not a great and glorious privilege denied the man who has been forced to remain at home?

"The remaining hours until bedtime belong entirely to the individual and he is allowed to follow his own will.

"All this has been designated as '*work*.'

Undoubtedly it is work to a few, but to the large majority it is a wonderful vacation out in the open, adding daily to the brawn and intellect of the man and embossed by the stimulus of having rallied to the defense of the country.

"In addition to the 'work' outlined these men are entertained with athletic sports, social affairs and vaudeville artists gathered from the commissioned and enlisted personnel of the whole camp—all of this practically without cost.

"I can not close this letter without referring briefly to the wonderful opportunity accorded 'the man.' This is primarily and entirely a camp of 'no fear or favor'; no section; no creed; no previous reputation; no pull or politics. Each and every man gets his chance and is judged and awarded accordingly. A wonderful, fair, unprejudiced school, lead and idealized by a wonderful man for the good of the *best*, and the advancement of all and the honor of America.

"JOHN E. BOYD,

*"Major, Medical Reserve Corps."*

## EXPERTS IN THE PREVENTION OF INFANT MORTALITY.

The United States Civil Service Commission announces an open competitive examination for experts in the prevention of infant mortality, for both men and women. Vacancies in the Children's Bureau, Department of Labor, at salaries ranging from \$2,400 to \$3,600 a year, with actual traveling expenses and a per diem in lieu of subsistence while absent from headquarters on official business, and in positions requiring similar qualifications will be filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer or promotion.

The duties of appointees will be to plan and conduct investigations into the causes of infant, child, and maternal mortality in selected communities, rural and urban; into the methods of their prevention; and into dangerous and injurious occupations and

other matters relating to the health of children. Appointees may also be required to investigate maternal and child welfare through the holding of conferences.

Competitors will not be required to report for examination at any place, but will be rated on the following subjects, which will have the relative weights indicated, on a scale of 100: (1) Education and experience, 70; (2) Publications or thesis, 30.

Graduation from a medical school of recognized standing and at least three years' specialization in the hygiene and diseases of childhood, or in the prevention of infant and child mortality by public or private agencies, are prerequisites for consideration for these positions.

Under the second subject, the applicant may submit publications on matters pertaining to child hygiene or the prevention of infant and child mortality, or a thesis on one of these subjects, or both such publications and thesis.

Statements as to education and experience are accepted subject to verification.

An oral test will be given at selected centers on a later date. In order to be eligible for the oral test competitors must attain an average percentage of at least 70 in education and experience and the publications or thesis. The oral test will be given to competitors in the order of their average percentages in the above subjects, and only to such number as will be necessary to meet the needs of the service. A competitor who fails to pass the oral test will not be eligible for appointment. Competitors will be notified of the date and place of the oral test.

Applicants must not have reached their fifty-fifth birthday on the date of the examination.

Applicants will be admitted to this examination regardless of their residence and domicile; but those desiring permanent appointment to the apportioned service in Washington, D. C., must have been actually domiciled in the state or territory in which they reside for at least one year previous to

the examination, and must have the county officer's certificate in the application form executed.

This examination is open to all citizens of the United States who meet the requirements.

Applicants should at once apply for Form 2118, stating the title of the examination desired, to the Civil Service Commission, Washington, D. C.; the secretary of the United States Civil Service Board, post-office, Boston, Mass.; Philadelphia, Pa.; Atlanta, Ga.; Cincinnati, Ohio; Chicago, Ill.; St. Paul, Minn.; Seattle, Wash.; San Francisco, Cal.; customhouse, New York, N. Y.; New Orleans, La.; Honolulu, Hawaii; old customhouse, St. Louis, Mo.; administration building, Balboa Heights, Canal Zone; or to the chairman of the Porto Rican Civil Service Commission, San Juan, P. R. Applications should be properly executed, including the medical certificate, and must be filed with the Commission at Washington, with the material required, prior to the hour of closing business on September 18, 1917. The exact title of the examination as given at the head of this announcement should be stated in the application form.

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#### COMPULSORY HOSPITAL LAW FOR NEW YORK PASSED AS WAR MEASURE.

The committee on the Prevention of Tuberculosis of the New York State Charities Aid Association was recently successful in getting the County Tuberculosis Hospital Law amended by the 1917 legislature, making the erection of hospitals mandatory in counties having more than 35,000 population.

The amendment was put through as a war measure, so that the state will be prepared to treat cases discovered in examining recruits or found in the army itself.

The new law affects twenty counties, eight of which had previously taken various steps leading to the erection of a hospital,

but had not yet let contracts. Of these eight, two have already signed contracts for an institution. Of the twelve which had taken no action previously, eleven have now taken certain definite steps, such as the appointment of committees to secure sites, the advertising for bids, etc.

The section of the law relating to the compulsory establishment of hospitals is as follows:

*"Establishment of county hospital for tuberculosis.* The board of Supervisors of every county in the state containing a population of thirty-five thousand or more, as determined by the latest state census, shall establish, as hereinafter provided, a county hospital for the care and treatment of persons suffering from the disease known as tuberculosis, unless there already exists in such county a hospital or institution provided by the county or other authority and caring for persons suffering from tuberculosis, which is approved by the state commissioner of health. Such county hospital shall be available for patients on or before the first day of July, nineteen hundred and eighteen. If the board of supervisors of any such county shall have failed to secure a site for a county tuberculosis hospital, and to have awarded contracts for the erection of suitable buildings thereon by the first day of January, nineteen hundred and eighteen, it shall be the duty of the state commissioner of health forthwith to proceed to locate, construct and place in operation a tuberculosis hospital in and for such county, the capacity of which shall not exceed the average number of deaths per annum from tuberculosis in such county during the past five years. For such purposes the state commissioner of health shall possess, and it shall be his duty to exercise all the powers which would have been possessed by the board of supervisors of such county, had such hospital been established and placed in operation by the board of supervisors thereof. All expenditures incurred by the state commis-



sioner of health for and in connection with the location, construction and operation of such hospital shall be a charge upon the county, and provision shall be made for the payment therefor by the board of supervisors of such county in the same manner as in the case of other charges against the county. At any time after such hospital has been in operation, the board of supervisors in such county may appoint a board of managers for such hospital pursuant to the provisions of this act, and thirty days after the appointment of such board of managers by such board of supervisors, such hospital shall be transferred to such board of managers, and such board of managers shall thereafter possess and exercise all the powers of the board of managers of a county hospital for tuberculosis under this act, and the state commissioner of health shall be relieved from any responsibility therefor except such responsibility as he exercises in regard to all county tuberculosis hospitals under the provisions of this act."

This legislation was drawn up as a result of the report of Dr. Hermann M. Biggs on conditions in France, and also of a report on a visit to Canada by George J. Nelbach, executive secretary of the committee. Mr. Nelbach reported regarding Canada's methods and resources for handling cases of tuberculosis found in the army in the May issue of the *News*, a monthly bulletin issued by his association. He reported two conditions, as follows:

"From the public health point of view, that is, from the standpoint of diminishing infection, two conditions relating to the system of hospitalization of the invalided tuberculosis soldiers seriously impair its effectiveness. The first is that the sick soldiers are not compelled to go to and remain in the institutions for care and treatment. They are still enlisted men and subject to military discipline, but public opinion would not now, at least, countenance the compulsory hospitalization of these cases. The country

knows that the sick soldiers returned from overseas are longing for the sight of their homes, the prospect of which has sustained them in irksome hours, and are eager to meet their kinsfolk and friends. The public and the press venerate these men who have suffered so grievously for their country. Enforced hospital care of these tuberculous invalids, in the present state of public opinion, would be considered harsh and inhuman, and undoubtedly would not be tolerated.

"Secondly, the institutions are relatively widely scattered and the military districts served by them cover enormous areas, excepting in the case of the three maritime provinces, Nova Scotia, New Brunswick and Prince Edward Island. The policy is to persuade the men to go to the sanatoria in the military districts from which they enlisted. But the districts are so large, with the exceptions noted, that the relatives and friends cannot readily visit the patients. The sick men become homesick; and weakened by disease, their initiative slackened by enforced idleness, their fibre softened by experiences that have been enervating, they waive their right for further care and treatment and return home, taking their disease with them and exposing their households to infection."

New York State, Mr. Nelbach concluded, could draw three important lessons from the experience of Canada. They were:

"(1) Adequate medical examination for tuberculosis of all men considered for the army.

"(2) Sanatorium care for the early cases rejected by the medical examiners should be provided by the state; and hospital care for the moderate and advanced cases thus discovered should be provided by the local communities, cities or counties.

"(3) Soldiers invalided because of tuberculosis should be kept under military discipline and required to go into tuberculosis hospitals for care and treatment. The in-

stitutions should be sufficiently numerous throughout the state so that the men may be placed in the hospitals that are close to the localities in which their kinsfolk reside, enabling the latter to see the men frequently, thus promoting contentment and a willingness to cooperate with the hospital authorities in pursuing the course of treatment."

The State Charities Aid Association has issued a pamphlet entitled "A Compilation of the Laws of the State of New York Relative to County Tuberculosis Hospitals as of June 1, 1917." A copy may be secured from the Association upon request.

## MORTALITY OF MOTHERS IN CHILDBIRTH.

### *Insured Women Show Improvement in 1916.*

More than two and three-quarter million women of child-bearing age, namely, between 15 and 44 years, are policyholders in the Industrial department of the Metropolitan Life Insurance Company. The largest number of them are wives and mothers. Among these women, 1,769 deaths occurred during the year 1916 from diseases and conditions incident to childbirth. The statistics of these deaths, which are particularly complete and accurate, will be of interest to the medical profession, to health and social workers and to the general public.

It is very gratifying to report a continued decrease in the death rate in the year 1916 from the causes associated with childbirth. The number of deaths was 70.1 per hundred thousand white female policyholders, ages 15 to 44, in 1911, and 62.6 per hundred thousand in 1916; which is a decrease of 10.7 per cent. Among colored women of the same ages, the rate was 88.4 per hundred thousand in 1911 and was reduced to 70.4 per hundred thousand in 1916; a drop of 20.4 per cent. In other words, the general conditions of mortality from the puerperal causes were practically the same among

colored women in 1916 as among white women only six years earlier.

### *Diseases Responsible for Maternal Mortality.*

Childbirth fever or puerperal septicemia was the most important of the particular diseases and conditions responsible for this maternal mortality. This single cause of death was responsible for 41 per cent of the total deaths from puerperal conditions. Albuminuria and convulsions associated with child-bearing were responsible for twenty-nine per cent and the accidents of labor for ten per cent. Accidents of pregnancy, chiefly abortions and miscarriages, caused 8 per cent of the total, as did also puerperal hemorrhage.

### *Decline More Rapid Among Policyholders Than in General Population.*

The consistent decline in mortality from these diseases and conditions among white and colored policyholders is in marked contrast to the practically stationary death rate from the diseases incident to childbirth in the population of the registration area of the United States. The latter fact was emphatically pointed out in a Bulletin on Maternal Mortality recently issued by the Federal Children's Bureau. In fact, the death rate among the company's policyholders is now lower from these puerperal conditions than among the female population in general, although the insured group is composed almost entirely of mothers of the industrial classes.

### *Effect of Public Health Nursing Upon Mortality From Childbirth.*

This more favorable condition among the insured females is in large measure the result of the extensive care given by the Visiting Nurse Service of the company to policyholders during pregnancy and after childbirth. In 1916, out of a total of 217,422 cases cared for, 42,124 or 19.4 per cent were concerned with maternity. Of these maternity cases, 30,189 were intensively nursed un-

der the direction of a physician, with an average of 1.7 visits per case.

As a result of this very encouraging mortality showing, the company has recently extended the privilege of the nursing service to female policyholders during the period of pregnancy, and two prenatal visits by nurses are allowed in addition to the eight nursing visits permitted after childbirth.

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#### THE WEST FLORIDA AND SOUTH ALABAMA MEDICAL SOCIETY POSTPONES MEETING.

On account of the chaotic conditions incident to the war, the absence of many members of the profession at the front and the general discouragement to travel and the holding of conventions, it has been decided to postpone the meeting of The West Florida and South Alabama Medical Society until further notice.

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#### PATRIOTISM WILL TELL.

Much has been said and written unofficially about the possibility of conscripting the medical profession to supply the desired quota of physicians for the immense army that our government is now raising.

Physicians are as essential to the success of an army as munitions and if our troops are to be the deciding factor in the terrible conflict now raging in foreign lands, the Surgeon General's office must be supplied with a sufficient number of doctors in the Medical Reserve Corps to take care of the full complement of troops in the field, on transports, in evacuation hospitals and base hospitals, in concentration camps, etc.

While it is no reflection upon any man's honor to be conscripted, at the same time we feel sure that a sufficient number of doctors will volunteer their services at an early date, which means considerable to the individual so applying.

It is reasonable to suppose that those who volunteer early and receive the benefit of instruction in a medical training camp, will

be the ones who will receive advanced commissions. The lowest commissions offered to a doctor is that of first lieutenant and it draws the pay of \$2,000 a year; captains receive \$2,400 and majors \$3,000.

The principal expense to a medical officer will be his mess charges or food, and this should not be over \$25 a month or \$300 a year in round figures.

Whatever may be the pay, the fact remains that the Surgeon General must have at least 20,000 physicians in the Medical Reserve Corps to supply the present demand, and we feel that the patriotism of the medical profession will be the stimulus that will induce a sufficient number of doctors to offer their services voluntarily.

Blanks for commissions in the Medical Reserve Corps are now appearing in medical journals or will be supplied you by the board in your own State. If you do not know the location of this board, the editor of this Journal will be glad to inform you or send you a blank upon request.

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#### ONE PHASE OF HOME DEFENSE.

"Protect the defective children, provide for their training and proper care, and you will lessen the burden of dependency and delinquency." This is the gist of the advice contained in a new report on Mental Defectives issued by the Children's Bureau of the U. S. Department of Labor, and appearing with special timeliness now that war conditions may tend to make more serious the problem of delinquent and dependent children.

The report is based on a study of the social conditions of 212 mental defectives in New Castle County, Delaware. A total of 115, or more than four-fifths of these, were in need of public supervision or institutional care because of bad home conditions, physical helplessness, or pronounced anti-social tendencies, and only 12 of them were provided for in an institution adapted to their care. Twenty-six of the defective children



were in industrial schools for delinquent children, and of these the report says:

"Institutions for the care of delinquent children are greatly handicapped by the presence of defectives, since they require special attention and exert a bad influence over the normal children. After a short period of residence these defectives are returned to the community without sufficient supervision."

Other defective children with delinquency records were at large in the community; in all, 98 of the 212 defectives studied were delinquent or immoral or difficult to control.

The report suggests that, while any program for the care of mental defectives must have as its central feature suitable institutional provision offering training or custodial care, according to the needs of the individual, other activities are equally essential. It is pointed out, for example, that institutional care is not necessary for all mentally defective children, for, contrary to the popular impression, it is found that there are certain types who safely can remain at home provided they have the attention and study which they deserve. However, special provision should be made for their safety, care and education, and out-patient work of an institution for the feeble-minded, in co-operation with schools, social agencies and families is referred to as a new and important method of providing in the most humane possible way for such children.

The possibilities of industrial training by which certain types of defectives may gradually become in part self-supporting and the importance of providing facilities for mental examination and diagnosis of doubtful cases are also brought out in the report.

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#### ERRATUM.

Our attention has been called to a typographical error that appeared in Doctor L. W. Cunningham's article entitled, "Roentgen Diagnosis of the Gastrointestinal Tract," published in the June number of *THE JOUR-*

*NAL.* On page 366, in the fifth line, the word sulphite is used in connection with barium instead of sulphate. The line referred to should read "ounces of barium sulphate in one pint of." Soluble barium is of course intensely poisonous.

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#### CHILDREN IN WARTIME.

How other countries provide from Government funds for the wives and children of their soldiers in active service, while the United States makes no such allowances, is described in the latest report by the Children's Bureau of the U. S. Department of Labor.

Separation allowances are granted not only in European countries where the pay of the private soldier of the lowest rank runs from 39 cents to \$7.30 a month, but in Canada and Australia which pay him \$33 and \$43.80 while he is engaged in foreign service. In addition to the soldier's pay the wife and children of the Canadian soldier receive from the Government \$20 a month; and the allowance to the family of the Australian soldier varies, according to the number of children, up to a maximum of nearly \$30 a month.

The pensions allowed by law to wives and children of soldiers killed in service are shown to be considerably higher also in Great Britain and the British dominions than in the United States. And the report describes various ways in which foreign governments are making an effort to meet the special needs of individual families.

In presenting this report to the Secretary of Labor, the chief of the Children's Bureau speaks of the general study of child welfare in the warring countries which is being conducted by the Children's Bureau and says:

"The relation of all these questions of child welfare to the living conditions behind the lines is clear. It is also plain that the living conditions in large measure depend upon the provisions made by the re-

spective Governments for soldiers and their dependents. And since the withdrawal of men from the ordinary walks of life to form a large army must create similar problems here, the question of what countries offer important suggestions for a system of soldiers' compensation in this country becomes at once basic to the consideration of child welfare in wartime.

"The material contained in the accompanying report, together with the earlier report upon the Care of Dependents of Enlisted Men in Canada, has been already utilized in drafting a proposed measure for soldiers' compensation in the United States by the Hon. Julian W. Mack, chairman of a special committee appointed by the committee on labor of the Council of National Defense for that purpose."

The American measure to which this refers has been endorsed by the President and by Secretary McAdoo. It has already passed the House of Representatives and is now pending in the Senate.

This bill would provide separation allowances to families of men in active service and would revise the scale of compensation to disabled men and their families and to the widows and children of men killed in service. It contemplates the organization of an effective system of re-education under Government direction based upon the experience of Canada and of Europe.

It also includes a provision, suggested by the Canadian municipal insurance, whereby the Government would sell life insurance at rates based on the cost of insurance in time of peace, the Government itself carrying the added cost of the war hazard. The maximum amount of insurance which could be purchased by one person would be \$10,000 and the privileges of the insurance would be open on the same terms to officers, enlisted men and members of the Female Nurse Corps. It is expected that the rate for a maximum policy will be such that any enlisted man could easily meet the premiums from his military pay.

## Reviews from Current Literature

### ACUTE LOBAR PNEUMONIA

Cole, Rufus: Report of Studies Concerning Acute Lobar Pneumonia. *Journal A. M. A.*, Vol. LXIX, 1917, p. 505.

The author reviews his work for four years as to the administration of specific serum in acute lobar pneumonia. Dividing the infection into four distinct types, his observations attribute one-third of the infections to type one, one-third to type two, ten or fifteen per cent to type three, the remainder to type four. The mortality in type one and two are moderately severe twenty-five to thirty per cent; in type three fifty per cent are fatal, and in type four ten to fifteen per cent. Since a number of hospitals, city and state boards of health are now equipped to determine the type of infection, the use of polyvalent serum in all cases of pneumonia is not advised. As yet there is no standardization of the serums

manufactured by commercial houses. When the specific type of the organism is determined, immediate administration of the serum is advised. The dose for adult is 75 to 100 c. c. and should be repeated every 6 or 8 hours until favorable results are obtained. He warns the practitioner relative to anaphylaxis comparable to such an occurrence in the administration of a foreign proteid as in diphtheria, emphasizing the use of a small portion of the serum into the skin (not subcutaneously) and waiting an hour for the reaction; if none, the serum should be given intravenously and very slowly, or diluted with sterile salt solution. A second form of reaction to the serum may occur, producing restlessness, tachycardia, suffusion of the face, sweating and occasionally vomiting, a reaction identical with that produced by injections of salvarsan, and the symp-

toms may appear at each injection. Finally the injection may produce a complex of symptoms, described as serum sickness, consisting of elevation of temperature, skin rashes, glandular enlargements, edema of the skin and joint pains, and these may occur seven to fourteen days following the administration of the serum. He concludes by stating that we now have evidence that the treatment of cases of pneumonia due to type one pneumococci with immune serum is of value in lessening the mortality from this disease. To produce the desired results it is extremely important that the disease be diagnosed early, that the type of infection be promptly determined, and that there occur no delay in administering the serum. The serum should be a specific one of known high "titer."

R. H. M.

#### HIGH CALORY DIET

Coleman, Warren: The Influence of High Calory Diet on the Course of Typhoid Fever. *Journal A. M. A.*, Vol. LXIX, 1917, p. 329.

Coleman claims to have established beyond question the value of high calory diet to the individual typhoid patient. His studies embrace a period of ten years, in Bellevue Hospital. Selected foods in large quantities are found to be taken without digestive disturbances. A comparison is made on patients with liberally selected diet and an equal number on restricted diet of 1,000 or 1,500 calories daily. The material consisted of 444 patients. The fibrile period and range of temperature are not affected by diet, but long convalescences are rarer. The mental condition of the patients is such that they keep the mouth cleaner. Nausea and vomiting is lessened in the high calory-fed patients. Tympanitis and diarrhea is observed in about half the cases on high calory diet than obtained on a milk diet. Nervous symptoms are less marked and in fewer number of cases. The body weight was reduced to a minimum and appetite improved. Complications are less and intestinal hemorrhage not so an important fea-

ture. Perforation occurred in two of the high calory cases and in seven fed on milk. Mortality 8.10 per cent in well-fed cases and 17.6 per cent on milk fed. He concludes by stating, "The mortality of the disease is reduced by from fifty to seventy-five per cent."

R. H. M.

#### ILEOCOLITIS

Aikman, John: Acute Ileocolitis in Infancy. *Archives of Pediatrics*, Vol. XXXIV, 1917, p. 504.

Conclusions are based on the study of 54 cases treated by the author in hospital. While etiology, symptoms, diagnosis and treatment are discussed, there is nothing strikingly new brought forward in connection therewith. Interest in the paper hinges largely on the excellent ideas expressed concerning prognosis. Mortality is about thirty-three per cent throughout childhood. The younger the child the higher the mortality. Infants under six months of age, poorly nourished and fed on condensed milk, have but little chance of recovery if temperature is over 102° F., accompanied by usual intestinal symptoms. If the infant is having convulsions and the above conditions exist, he has no chance.

The more mucus in the stool the worse the prognosis. While the presence of blood in the stool is a bad sign, the amount of blood bears no relation to the severity of the disease or the gravity of prognosis. Pus in the stool is a bad sign. Severe vomiting, toxæmia and convulsions all constitute bad signs. The higher the temperature the worse the prognosis. Pulse is a poor guide except toward the end of life when it becomes weak and irregular. The condition of the abdomen can not be used as a guide. The average duration of the fatal cases was nine days, of those cases recovering three weeks.

If the child survives the first week, his chances of recovery steadily improve. Nothing new is offered as to treatment, though the opinion is expressed that serums are of



little value and the bulgaricus bacillus cultures not to be depended on. J. D. L.

### HEAT AND INFANT MORTALITY

Du Bois, C. C.: Heat and Infant Mortality. *Archives of Pediatrics*, Vol. XXXIV, 1917, p. 516.

While for some time past there has been a tendency to reduce all causes of infant mortality to the bacterial standard, the problem of temperature, as the cause of high death rate, has recently been elevated to a position of prominence.

Anything that interferes with heat conduction and radiation shows its effect more quickly in the infant than in the adult, since the skin temperature of the infant is from 3° F. to 4° F. higher than of the adult.

External heat will cause an actual rise of body temperature in the infant, metabolism is on a higher plane and the heat regulating apparatus less efficient. At a room temperature of about 88° F. loss of body heat through conduction and radiation is negligible, and heat elimination must take place through evaporation of moisture. For these reasons room temperature and infant clothing demand first thought. Excessive heat lessens resistance of the organism to intestinal bacteria. Partially decomposed milk may be harmless if fed to infants in cold weather.

The most frequent causes of summer morbidity and mortality are poor heat elimination, high external heat and excessive food. These factors can be largely met by giving less food, thus decreasing heat production; increasing heat elimination by scant clothing, good ventilation and frequent bathing; guarding against infection through food and otherwise. J. D. L.

### THE REMOVAL OF TONSILS

Perry, Richard W.: The Removal of Tonsils as a Prophylactic Measure in All Children of Four Years of Age. *Laryngoscope*, Vol. XXVII, 1917, p. 490.

Perry takes the ground that the tonsil is without function, i. e., that it is simply a lymphatic gland and not an organ.

"It is the open door to disease and just as the inguinal canal is a weak spot in the wall of the abdominal cavity, so the tonsil is a breach in the defensive armor of the body. The tonsil is an irritative hyperplasia of a lymphatic gland. He cites Nature herself as the great tonsil remover, the tonsil being replaced by scar tissue. This is unfortunately a very slow and often incomplete process, and when incomplete is a constant source of infection and trouble."

He gives the following as some of the diseases for which the tonsil has been blamed: Rheumatism, tubercular glands of the neck, chronic tonsillitis, quinsy,\* aural catarrh, laryngitis, glandular fever, appendicitis, osteomyelitis, ulcer of the stomach, general sepsis, meningitis, anæmia, iritis, pleurisy, endocarditis, pneumonia, nephritis, orchitis, goiter, St. Vitus dance, acute infectious diseases of children, diphtheria, scarlet fever, cerebro-spinal meningitis.

Streptococcus is a normal habitat of the mouth and this accounts for many of the above diseases.

He quotes from the report of Dr. Brown, superintendent of the school clinic of Seattle, as follows: "One child in every twenty that we examine has albumen in the urine. This albumen can usually be traced to a tonsillar origin and clears upon tonsillar enucleation. One child in every thirty has heart lesions, which in every case can be traced to previous tonsillitis. Four in every hundred of the older boys are excluded from strenuous games on account of valvular lesions of the heart, all of which cases give a history of sore throat \* \* \*. It would be impossible to overdraw for me the picture of tonsil perfidy."

Dr. Cullen Welty, of the San Francisco isolation hospital, says: "We have not had a single case of diphtheria when the tonsils have been completely enucleated."

Dr. Wilson Johnston declares that universal tonsil enucleation would put half the laryngologists and children's specialists out

of work. "There is no direct evidence that it has any function, and if we used our microscopes more and our imaginations less we never would have looked for the gland to have a function beyond that of any ordinary lymphatic gland.

"In conclusion, then, I wish to go on record as advising the removal of every tonsil at four years of age, irrespective of its condition, or as much younger as infection may indicate. In view of the tonsil's lack of any proven function, its ease and safety of removal and its baneful effect on the economy, I do not see how any scientific reasoning can arrive at any different conclusion."

W. S. M.

#### RELATION OF THE ROENTGENOLOGIST TO THE PHYSICIAN AND SURGEON

Blaine, E.: Relation of the Roentgenologist to the Physician and Surgeon. Ill. Med. Jour., Vol. XXX, 1916, p. 338.

Blaine criticises the present-day attitude of the average physician toward the roentgenologist and voices the opinion that an injustice is being done; and further that this attitude is out of keeping with the usual scientific atmosphere with which the better order of medical work is associated. He realizes that this unfairness is not usually wilful and that it has resulted from faulty precedents.

A clear distinction is made between the so-called "X-ray expert," who in many instances is a non-medical man, and the roentgenologist. It is a pity that the "X-ray picture takers" have not found their proper commercial sphere as "photo-gallery artists." It is sad but true that any of the so-called X-ray laboratory "directors" are unsuccessful physicians who have failed in their regular legitimate practice. Some such come dangerously near the border-line of quack X-ray physicians. Such quacks are as much a reality as the quack doctor or the quack dentist. Will the doctor refer his wife or his children to such? If not, then why send his patients there?

The fault is somewhat with the profession

at large, for they judge the photographic ability rather than medical skill. The finest X-ray plate may not give any more information than one less brilliantly made. In his summing up, Dr. Blaine itemizes a number of conclusions which will bear careful consideration:

1. An X-ray examination is a special medical work; the object in view is the diagnosis, not X-ray pictures.

2. The roentgenologist is a medical consultant in each and every case referred to him, and his fee should be in accordance with the skill required in the case, not the number of views or plates.

3. An X-ray diagnosis is of value only when the shadows obtained are correlated with the history, symptoms, clinical findings, etc.

4. X-ray examinations and treatments should be performed only by regularly qualified medical men who have had special training and experience in the work.

5. The ability to make photographically pretty roentgenograms should not be the principal point in judging the roentgenologist; the real factor is skill in interpretation and medical ability.

6. In addressing his patient the doctor should not speak of "X-ray pictures," but should use the term, "X-ray examination," thus avoiding the idea that pictures are to be obtained by the patient.

7. X-ray laboratories with high sounding names are often run by directors who are incompetent as roentgenologists, and many hospital X-ray departments are in charge of inexperienced internes, non-medical men, with practically no training, sisters, et al. This should be considered in judging the value of the work done.

8. Opinions asked of the roentgenologist on roentgenograms made by some one else are medical consultations, and he should receive proper compensation for the service rendered.

9. Patients should not be given any plates or prints, but should be advised that they

are paying for an X-ray diagnosis, not pictures.

10. Finally, every physician and surgeon should give that consideration for the work and opinions of the roentgenologist that he expects for his own. L. W. C.

### SYPHILIS OF THE STOMACH

Eusterman, George B.: Syphilis of the Stomach, a Clinical and Roentgenographical Study. *Am. Jour. Med. Sc.*, Vol. CLIII, 1917, p. 21.

The author reports twenty-three cases of syphilis of the stomach which have been so far observed at the Mayo Clinic. He states that it is generally conceded that the clinical picture resembles that of non-specific gastric disease, but the different results of the therapy will dispel the suspicion to such an extent that in cases where atypical gastric disturbances do not respond to ordinary dietetic and medicinal treatment, the suspicion of syphilis is very frequently justified.

Marked deformity of the stomach outline and motility as seen on the plate or the screen with the lack of cachexia seen in malignancy are the usual roentgen signs. A roentgen diagnosis of probable syphilis of the stomach can be made. This confirmed by a positive Wassermann and further by improvement under specific therapy absolutely establishes the diagnosis. L. W. C.

### HOOKWORM INFECTION

Foster, George B., and Sinclair, Charles G.: Hookworm Infection as a Medico-Military Consideration. *Journal A. M. A.*, Vol. LXIX, 1917, p. 431.

This article is of special importance to all health workers in the South, and as so many of the troops from the North are quartered in the South, it may point to a problem to be considered by all. The study was suggested by the incidence of many cases of pneumonia and measles among the Alabama troops stationed at Nogales, Ariz., in the period for October, 1916, to March, 1917. Official data submitted by the organization commanders of the First Alabama Infantry, covering a four-month period, October 24, 1916, to February 24, 1917, shows that of

the 963 composing the regiment, 809, or 84 per cent, had been on sick report for some cause; that of 1,002 men composing the 4th Alabama Infantry, 859, or 85.7 per cent, had reported sick. Figures for the 2nd Alabama Infantry were not available, but it was thought that the morbidity approximated the other regiments.

During this period there were no epidemics among the civil population comprising, for the two Nogales, 8,800 inhabitants.

The morbidity rates for all other troops were never abnormally high. Rations, shelter and disposal of waste were the same for all troops, hence, it was apparent that factors not common to the other troops determined the high morbidity in those from Alabama.

Malaria and hookworm were the two possibilities that presented themselves, but after a short period of examination malaria was ruled out. The hookworm survey consisted of the examination of 1,259 men and the ova were demonstrated in the feces of 503, or 39.9%. Of 744 examined from the 1st Alabama Infantry, 342, or 45.7% were found positive; of 366 from the 4th Alabama Infantry, 96, or 26.2%, and of 149 from the 2nd Alabama Infantry including only those who were sick in the hospital, 65, or 43.6%, were found positive.

It is important to note that those from the rural districts of the southern and central portions of the State gave a higher rate of incidence than those from the northern portion where the soil is not as favorable for the hookworm.

Unless all carriers of the hookworm in the army are cured, how easy it will be to spread the infection not only to all parts of the United States but also to the fighting front where opportunity for spread will be very great.

The authors found that the presence of hookworm infection rendered these men, supposedly in the pink of condition, very susceptible to other infection.



Is it not fair to ask the question how much bearing does this condition have on the high morbidity and mortality rates of the South?

B. L. A.

## Publisher's Notes

### DIPHTHERIA ANTITOXIN ESSENTIALS.

Antitoxin for the treatment of diphtheria should have its origin in the blood of sound, vigorous horses—animals that are well cared for; that are maintained in an atmosphere and environment conducive to health. It should be produced under conditions of asepsis and by modern methods. Its manufacture should be entrusted only to the experienced, to those who are scientifically trained, to those who are equipped with ample facilities. Anti-diphtheric serum produced under such conditions bears a substantial guaranty of safety and efficiency.

Reference to the work of Parke, Davis & Co. as antitoxin producers is pertinent in this connection. Parke, Davis & Co. were among the earliest of American manufacturers of diphtheria antitoxin, as for many

years they have been the largest. They maintain a stock farm of more than seven hundred acres, where, under ideal conditions, their serum-producing horses are kept. Their biological stables are supervised by skilled veterinary surgeons and are provided with good light, ample ventilation and a perfect system of drainage. The horses are subjected to rigid physical examinations, and no animal is eligible until he has been pronounced sound by competent veterinarians. Operative work in connection with the immunization and bleeding of horses is conducted in accordance with approved surgical methods. The laboratories in which the antitoxin is prepared, tested and made ready for the market are the admiration of scientific men who visit them. The purity and potency of the serum are established by an elaborate series of bacteriologic and physiologic tests.

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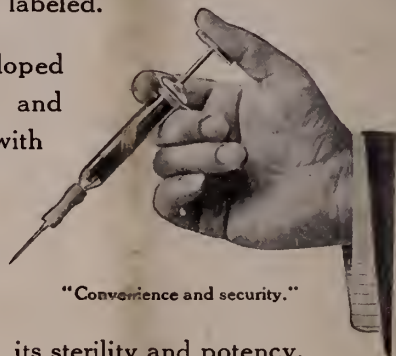
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THE JOURNAL  
— OF THE —  
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OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV  
No. 5

St. Augustine and Jacksonville, Fla., November, 1917

Yearly Subscription, \$1.50  
Single Copy, 15c.

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, November, 1917

Number 5

## ORIGINAL ARTICLES

### TUBERCULOSIS AND THE PROBLEM IT PRESENTS.\*

R. H. MCGINNIS, M. D.,

Jacksonville, Fla.

I take it that the Chairman of the Civilian Relief Committee of the Associated Charities wishes this subject discussed from a sociologic viewpoint, and bearing this point in mind I will have little to say relative to the medical aspects of the disease other than those intimately associated with its social problem, and in a short paper I can only hope to discuss its most salient features.

Tuberculosis is an infectious, contagious disease due to the implantation of the tubercle bacillus. The lungs are affected in 90 per cent of cases. No tissue of the body is exempt from the infection. The disease is probably contracted in very early life either through the respiratory or intestinal tracts. The bacilli entering the system by either of these routes find lodgment in some of the glands about the body, in most instances those glands situated in the chest at what is known as the "root of the lungs." These glands, then, are the supply stations to the rest of the body for the dissemination of the germs in the event the body resistance becomes lowered. If the body resistance is maintained by proper living, sufficient and wholesome food and uncontaminated air day and night, these germ-infected glands form the barrier that protects the system from invasion. The active tuberculous victim, liberating the germs in his sputum and other excretions, is a source of reinfection to himself and to those with whom he may come in contact. We may call such a person a "focus

of infection." In my opinion, if the control of the focus of infection can be accomplished, the problem of tuberculosis will have been solved. That is a great task and presents many difficulties, but by constant effort, in various and sundry ways, the mortality from tuberculosis has been reduced twenty-five per cent in twelve years. Some encouragement, isn't it? This result has been brought about by educational and institutional means and a large proportion of the deaths prevented have been among those who were sufficiently intelligent to profit by instruction rendered by these means. Eighty to ninety per cent of the tuberculous, however, are poor, improvident and ignorant, living in insanitary, unhygienic quarters, with inadequate, inappropriate and unwholesome food supply and the inability to apply instruction. It is with this class of people that sociology finds its most difficult task, and in my opinion, control of the victim of tuberculosis and the protection from the spread of the infection to members of the family or inmates of the house is impossible. It matters not how much visiting and instruction by the philanthropic and charitably inclined, there will be a relaxation of vigilance, lack of proper appreciation of constant care of spitting, coughing and sneezing, laxity in the cleanliness of the house and preparation of the food, faulty sense of the quantity and quality of rest and exercise and a misconception of the value of fresh air day and night.

In these homes of the poor are usually a goodly number of children, poorly clad, poorly nourished, sleeping together in a few or one bed in illy-ventilated rooms, and if too young to be out of doors, playing about the house and upon the floors where the

\*Read before conference of Anti-tuberculosis and Red Cross Workers, at Jacksonville, September 20, 1917.



careless spitter has deposited his infected sputum. Is it any wonder that the child becomes infected? No child is born with tuberculosis. They contract it. Many of these children die of the disease early and some resist the spread of the infection in their bodies, the bacilli being encapsulated in some glandular structure, to be released later in life when body resistance is lowered. Some live to old age, because of a protective immunity manufactured by the body. So the problem continues from generation to generation. It is conceded that a small proportion of tuberculosis is contracted in adult life by intimate, close contact with the focus of infection for a reasonable length of time.

The problem presented, what is the remedy? Constant and persistent work along the lines of education, hygiene, sanitation, sanatorium care and control, and again sanatorium, hospital or preventorium control of the victim of the disease. This sanatoria control, especially among the indigent, must be met by unit institutions, established and maintained by county and state taxation. The smallest unit under such a program is the county, and each county should take care of its own indigent, sick or well. Two or more counties might combine in a unit when necessary. These unit institutions will become educational and instructive to the patient and public, at the same time concentrating the foci of infection. Not only should the diseased individual be cared for, rehabilitated and brought back to a condition of earning capacity, but the family of the victim should receive county and state aid if necessary. Also the family should have the advice and instruction essential as to the proper and wholesome manner of living. So much for the indigent.

The following lines are taken from my article† read before the State Medical Association at Atlantic Beach, May 19, 1917, relative to the middle and rich classes:

"In the homes of the middle class the care

and attention of the tubercular sick will devolve upon a member and possibly two members of the family. This will lessen the finances necessary to maintain the family and home, lessen the means of obtaining the best of food and surroundings for the victim, and expose the caretaking members of the home to continued chances of contracting the disease.

"In this class, also, the sanatorium, or preventorium, which is a better term, removes the focus of infection, relieves in a measure the anxiety of the family and returns the attendant or attendants on the sick to lucrative pursuits. In this class of cases the family could cooperate with preventorium authorities, bearing a portion of the expenses necessary to maintain the patient in suitable environments and surroundings. In such a division of the responsibilities the family and county or state will share, and both be mutually benefited, at the same time offering the patient the best chance for restoration to health and productiveness.

"Home treatment for the well-to-do is a simple matter and resolves itself into expenditure of money to place the patient in proper surroundings and the providing of proper food and care. However, the rich seek sanatoria treatment, as they find it preferable."

As a supplement to this paper I append the following aphorisms, relative to tuberculosis, from the pen of Dr. Lawrason Brown, Saranac Lake, N. Y., appearing in the *American Review of Tuberculosis*, June, 1917. Dr. Brown's article appeared after the above paper was written:

"Absence of tubercle bacilli in the sputum means only that bronchial ulceration has not occurred."

"The uncertainties of prognosis decrease rapidly after the first year of disease, but are ever present."

"He who promises a patient what is unattainable injures himself more than the patient."

"Recovery in pulmonary tuberculosis, like

†McGinnis, R. H.: The Early Diagnosis and Home Treatment of Pulmonary Tuberculosis. *Journal of the Florida Medical Association*, 1917, p. 330.

recovery in carcinoma (cancer) can occur in the apparently hopeless, but does occur very rarely."

"Tuberculous parents (when the child is under two or three years of age) increase incalculably the chance of infection. Hence the importance of exposure to family infection has often been transferred to inheritance, which beyond this exerts no definite proven influence."

"The mentality and characteristics of the patient's family, their ability and willingness to help in his recovery by self-sacrifice over long periods of time, are most important. Therefore, recovery in the midst of the family is a most favorable recovery."

"Poverty snatches recovery from the grasp of many a patient, but money is only an adjuvant, not a means, to cure."

"Recovery in a climate in which a patient is to live, especially if accomplished at home, bespeaks greater longevity than immediate change of climate on arrest of the disease. Climate may be only a minor factor in this effect."

"Duration of treatment of less than three months is of little permanent help, while three or four years of treatment may complete an arrest."

"There is no disease for which the medical profession can do so little actively as for steadily advancing pulmonary tuberculosis."

"The treatment of pulmonary tuberculosis demands little knowledge of drugs but much about the immediate and prolonged education of the patient."

"Whatever advantages the sanatorium and the class system of certain physicians possess, and they are many, lie in the fact that these institutions are really teaching institutions and the physicians are educators."

"The idea that pulmonary tuberculosis is a most curable disease is a fallacy."

"The time allotted to treatment is usually too short, for recovery is ever longer than onset. The value (possibly the results) of treatment increases as the square of time,

that is, two years are four times as valuable as one, but the struggle lasts often from diagnosis till death."

"The patient is worried, confused, twists what is told him and can master the thousand and one details only by repeated persuasals of directions carefully written down. He should not be blamed for the physician's mistakes of omission. Word of mouth, however, conveys to the patient emphasis and force and directness that tons of tomes cannot."

"At home and abroad, in the desert or on the ocean, in the lowlands or upon the mountains, patients may do well, as they recover anywhere and everywhere, for it matters less where than how they live."

"Fresh air, one hundred times more frequent outside than in, depends for its value far more upon the temperature, moisture and movement of the air than upon any organic or inorganic constituents."

"The skin demands better air than the lungs, for we can breathe with impunity far worse air than we can live in. Hence the lungs are benefited by fresh air no more, no less, than any other organ."

"The dose of fresh air needs less attention than the development of a fresh air conscience which suffers when its owner crosses the threshold into the house."

"The sanatorium, the best place in which to treat patients in large numbers, has shown that permanent arrest may follow effectual treatment; the hospital has afforded evidence that direct contagion may in part be controlled, while the dispensary has become the advanced attacking line, so to speak, that carries the warfare into the enemy's camp, that is, into the home of the tuberculous, and disposes of the wounded in the proper way."

"The length of stay in these institutions depends upon the object to be attained: for permanent recovery two or three years, for quiescence at least three months; for prevention of infection from far-advanced cases, as much as possible of the time between admission and death."

"Give your patient as little food as will serve his purpose and have clearly in mind what this purpose should be: to gain up to and ten to twenty pounds beyond his usual weight."

"Remember that too much food may in the end prove as disastrous as too little food, and furthermore, that it is a great pity to waste good food."

"See that your patient has a well-balanced ration and, if you wish him to gain weight, increase his carbohydrates."

"Insistence upon absolute quiet and its observance for six weeks affords rest for repair, time for growth of scar tissue and opportunity for the walling off of areas of disease in the early stages. Such periods of rest in later stages accomplish no such results."

"When such a period of rest has been practiced, exercise can be more quickly increased with little danger of relapse."

"Exercise should be regarded as a powerful and dangerous medicine, to be used carelessly never, with impunity by none, and as a deadly drug by all."

"Work for therapeutic purposes is fraught with much danger and is more safely replaced by work which fits the patient for his future occupation."

"Since the vast majority of patients must seek treatment only in the climate in which they contract the disease, the so-called climatic treatment is of importance to hardly more than five per cent of all patients."

"Those with acute tuberculosis, cachexia, marked dyspnoea, with cyanosis, advanced nephritis, diabetes without carbohydrate tolerance, intractable diarrhea, extensive laryngeal tuberculosis with dysphagia, or pneumothorax, are best treated in a hospital near their homes."

"It is criminal to advise an untrained patient to seek benefit from climatic change without constant medical advice."

"Beyond the empirical fact that many patients do better for some change, much

has been written but little proved about climatic treatment."

"There is as yet no accredited specific (like 606 for lues) for tuberculosis."

"Drugs may alleviate or even remove for the time being certain localizing and constitutional symptoms, but affect in no direct way the disease that produces them."

---

### SOME PRACTICAL SUGGESTIONS CONCERNING ELECTRICITY AND VIBRATION IN GASTROINTESTINAL AFFECTIONS.

GEORGE M. NILES, M. D.,  
Atlanta, Ga.

Clinical observation and experience have demonstrated that electricity in various forms exercises an actual and tangible effect upon the secretory and motor functions of the stomach, and also, to a certain extent, on its sensibility.

At the present time there is much controversy concerning the real effect of electricity intragastrically employed, some physiologists decrying its value, while competent clinicians are reporting marked benefits in numerous cases. Even among stomach workers there is diversity of opinion. Einhorn believes that the faradic current promotes secretion, and the galvanic impedes it; Hoffman, that the galvanic current increases secretion, and Brocci, that the faradic augments both secretion and peristalsis. Bassler believes that the effects of the galvanic current are of a sedative nature in the relief and control of abnormal disturbances of gastric sensation, and that it has a mild inhibiting effect upon some stomachs on the hydrochloric acid secretion, but not as often on the quantity of enzymes; and that the faradic current is of value in the myasthenic states of the muscular tissue of the stomach, provided the pylorus is patent, and also if the deficient musculature has not gone on to paralytic atony. Added to this is an effect (probably complex in its nature) on the abdominal sympathetic system, in which



the nutrition of the stomach wall as a whole is improved. Whether this is due to the massaging of the stomach walls by the contraction of the muscle fibers from the current, or is due to some direct action of the current on the nerve endings and centers in the posterior abdomen, is not certain. Furthermore, it has a somewhat mysterious but none the less beneficial effect in perhaps a suggestive manner upon many individuals suffering from gastric troubles of possibly a neurotic character. Because we can not fully explain its action, is no reason why we should not avail ourselves of its aid.

Bassler reports two most instructive cases, studied by him per X-ray, in which he proved that the faradic current increases peristalsis, and causes the entire stomach to become smaller in size. One was a case of gastroparesis in a young woman, and the other a simple atony following the taking of too large quantities of fluids in a young man who worked as a coal stoker in an engine room. His observations were conducted with bismuth subnitrate and water in an otherwise empty stomach, when he noted distinctly a mild running peristalsis in the lower half of the stomach in both instances. After the electrode was introduced and before the faradic current was turned on, the peristalsis was somewhat more marked; possibly due to presence of the cord and end piece within the organ. When, however, the faradic current was delivered to the tolerance of the person (external electrode at the sides of the neck) and evident contraction of the entire organ took place, it was followed by a less degree of relaxation and increased peristalsis.

Speaking somewhat generally, I might say that the best results are obtained in atonic stomachs with sluggish motor power, by the use of the faradic current, with the positive end of the current discharged within the stomach, and the external electrode (negative) on the back or preferably on the epigastrium.

In regard to the power of the current no

inflexible rule can be laid down. It should be given to the *comfortable* tolerance of the patient, and not pushed to discomfort. Nearly every patient will display a difference in tolerance, and each one must be a rule unto himself. From 5 to 20 milliamperes is an average requirement.

Numerous intragastric electrodes have been devised, of which the most practical are Bassler's, Lockwood's and Einhorn's.

Bassler's seems to possess some advantage in the "introducer," which is withdrawn after the bulb enters the stomach. Some patients find it rather difficult to swallow the rubber fenestrated capsule.

The electric treatments should last from eight to twelve minutes, though the faradic can with propriety last somewhat longer than the galvanic. The patient should always have one or more glasses of water in the stomach. The external electrode may be gently moved about, and the current may be gradually increased from time to time. Should the patient become nervous or ill at ease, the treatment should be cut short, for it can do no good under such circumstances, and might do harm. Care should be taken that the current is not painful, and the operator should remember that the wetter the sponge the greater is the intensity of the current.

When it seems desirable to permit the current to flow to a large external area (the back), the large external electrode may be used in place of the hand instrument. In cases of vague pains in the back, associated with loaded colon, autointoxication, gastric neurosis, etc., it is of much value to place the large electrode over the area corresponding to the great sympathetic plexuses in the upper abdomen. As to frequency of treatments, I usually administer intragastric electricity every second day for one to two weeks; then two or three times weekly for two more weeks; then once a week for as long a time as may be indicated. This schedule is modified at all times by the patient's temperament, convenience, sometimes in-

clination and by the results apparently attained.

*Percutaneous Electricity.*—Some patients do not seem able or willing to undergo intra-gastric electricity, and with these it is sometimes advisable to administer it entirely from without, with the idea that the current employed will course directly through the body and therefore through the desired viscera. There is probably no branch of therapeutics in which we get more contradictory reports than concerning electricity, and many of these reports are colored with an optimism that would make the late Sinbad the Sailor open his eyes in surprise; while others, with just as much pessimism, find absolutely no benefit from any kind of electricity.

Having had occasion to use electricity quite often in gastrointestinal work, and with apparent benefit, I have come to certain conclusions, which I will briefly state.

By the use of a fairly large epigastric electrode, which is placed over the stomach or lower down over the abdomen, and a smaller electrode, placed on the spinal column directly opposite, a current will be sent through the organs desired. This current may be regulated according to the sensibility and comfort of the patient, making it distinctly perceptible, but never uncomfortable. The patient should generally lie on the side in an easy position, and can assist the operator by holding one of the two electrodes. The treatment may last from six to twelve minutes.

Apart from the general rule that the currents will connect through the shortest distance, we can not be sure as to the special conductivity of any particular organ, and we therefore have to rely on a certain amount of diffusion of the electricity as it courses through the body.

I have principally employed this form of electricity in the various so-called gastric neuroses, gastroptosis and enteroptosis, dilated and atonic stomachs, flabby and incompetent abdominal parietes, chronic colitis, mucous colitis, gastralgiæ, nervous

anorexia, and the many vague epigastric and abdominal discomforts, in which the patient can not give a succinct description of his troubles, but constantly and bitterly complains.

In many of these patients the electricity is employed somewhat empirically, but none the less successfully. Just how much of the improvement is brought about by psychic means I am unable to say. Probably much of the benefit should be attributed to the novel sensations which start a favorable "wave of improvement" deep down in the sub-conscious personality, which in turn exerts a beneficent influence on the sensory centers. This I admit is to a great extent speculative, and I simply state that in many chronic cases, where various forms of rational and logical treatment have been without avail, electro-therapy has wrought most satisfactory results.

Its use should not be condemned because we do not thoroughly comprehend its action, but from its many apparent good results, we are justified in availing ourselves of its possible advantages.

*Static Electricity.*—This has been recommended in much the same types as call for faradic or galvanic electricity. It has been found useful in flabby and dilated stomachs, and in gastric and intestinal neuroses. Especially favorable has been the effect of static electricity in the run-down class of "nervous dyspeptics," whose minds continually dwell on their digestive organs, and whose waking thoughts are entirely introspective. In these cases the static current administered rather energetically for ten or fifteen minutes daily seems to act quite favorably, exciting a new train of sensations, and steadying the somewhat unstable nerves. In cases of nervous indigestion, wherever practicable, I always avail myself of the static current. Unfortunately, this procedure is available in only a limited number of cases.

Before passing on, I wish to very briefly mention electrical treatment in esophageal diseases. For esophagismus or cardiospasm

electricity is often indicated, and will in some instances afford brilliant results. Other disorders of the esophagus, when reflex or apparently neurotic in origin, are amenable to this agent. I wish to caution my readers, however, as to expecting any material improvement from electricity in cicatricial stenoses of the esophagus with malignant tendencies. The dissolving of cicatricial tissues or the relief of stenosis by electrolysis has not proven effective, and instead has changed ill-advised hope into black disappointment many times. It would be most unwise on the part of the physician to hold out to a patient with a stenosed esophagus any strong promises of either ultimate or lasting improvement by electricity in any form.

The Roentgen ray, as a therapeutic agent, being in a separate and distinct class, will not be considered in this study.

*Vibration.*—This method of treatment has been extremely popular, and many forms of vibrators have been devised, some of them quite expensive. They have varied from the simple hand-vibrators, costing but little, up to the elaborate and expensive contrivances. Many of the patented machines which have been extensively advertised and foisted upon the public as wonderful discoveries were in reality only vibrators masking under high-sounding names. It must be admitted that vibration, when properly applied, does exert a beneficial effect upon certain disorders of the alimentary tract, and the subject will be briefly discussed.

There are several hand-vibrators on the market (the Vedee and the Eureka) which can be used where electricity is not available. There are many others that can be attached to the street current in the patient's residence or in the physician's office.

There are other small hand-vibrators now manufactured and also small vibrators which can be run by a portable storage battery, thus making them available to all.

Vibratory massage should be given from left to right over the stomach for three to

five minutes, then two to three minutes to the left of the seventh dorsal vertebra, and then about two minutes more over the stomach.

When vibrating over the colon, the general course of the large intestine should be followed, giving most of the vibration over the sigmoid. In the early morning hours, or before breakfast is the best time to vibrate the intestines, while later in the day, after nourishment has been taken, is the better time for thus stimulating the stomach and nearby viscera.

Bassler has recently devised an electro-vibrator, which seems to combine the benefits of mechanical vibration and electricity. He has employed this method in disturbed states of motility, sensory and secretory conditions of the stomach, and claims better results than with the single forms of physical treatments. The best results in his opinion were attained in those cases in which the gastric disturbance was secondary to enteric disturbance. Bassler sums up his experience in a broad way, and I quote him at some length, as his views express in a fairly complete manner the indications and contraindications for electro-vibration:

"Electro-vibratory massage is of value in the therapy of abdominal conditions in all motor, some sensory and a few secretory, disturbances of the intestines both locally and as they may directly or reflexly affect the stomach or other parts of the body; that it is a measure of value in the disturbed states of local nutrition of the reachable abdominal organs, and in the abdomen as a whole—its influence here is to better the general state of health, and favorably influence those catabolic and neurasthenic conditions which take their origin in the abdominal cavity; that it is the best single medical measure we have today in the treatment of exudates and fibrous adhesions found about the abdominal portions of the alimentary canal; that in those mysterious tardy forms of intestinal indigestion, and also in the long-standing catarrhal condi-



tions, it might be employed with satisfactory benefit to a patient; that it is the best form of percutaneously applied physical treatment we have for abdominal conditions, ahead of hand-massage, vibration, or the externally applied battery current; that its use should always be preceded by an accurate diagnosis, since in some of the conditions of the gastro-enteric tract it might do positive harm (malignant disease, ulcers of any type, acute catarrhal and suppurative states); that following a plausible indication for its use, it should be employed by the physician himself, or under his immediate direction, in suitable combination for the case in the way of the plan of massage and selection of the current; and that, lastly, it should be employed with a consistent and, if needs be, long-kept-up effort to accomplish these ends."

In applying vibration the patient should lie at ease on a long table and the skin should be dusted with some prepared chalk or talcum powder, so that the instrument will move easily on the surface. The patient should relax the abdominal walls as much as possible, and should assume a comfortable position, so that none of the muscles are taut. The treatment may last from three to ten minutes, regulating both the rate of vibration, the strength of current, and the force of pressure according to the susceptibility of the patient.

I have used this method in quite a number of selected cases, and feel that too much has not been claimed for it. Apart from any real therapeutic effect it may possess, it certainly exerts a powerful psychic influence, and few there are, who after being electrically vibrated for a time, do not report tangible sensations of braced and steadied nerves, plus a much more comfortable abdominal feeling.

Members of the Florida Medical Association entering the Medical Reserve Corps are urged to notify THE JOURNAL of their change of address.

## REPORT OF A CASE OF MACULO-ANAESTHETIC LEPROSY.\*

J. L. KIRBY-SMITH, M. D.,  
Jacksonville, Fla.

The occurrence of leprosy in Florida is undoubtedly uncommon, nevertheless from time to time cases are seen. In certain sections of the state, namely the extreme southern part, leprosy is somewhat prevalent. The writer has had the opportunity of seeing five cases of the disease that had their



Fig. 1. Tubercular Leprosy.

origin in Monroe county. In 1913 a case of nodular or tubercular leprosy was reported before the Duval County Medical Society; this case, a negress, originated in Duval county. The accompanying photograph shows the facial involvement. This case was published in the *New York Medical Journal* for October 11, 1913, mention

\*Read before the Duval County Medical Society, at Jacksonville, February 4, 1917.

being made of the fact that a careful investigation failed to reveal the possible source of the infection. Unquestionably, leprosy in its milder manifestations may exist without the patient being greatly inconvenienced. These mild cases with few cutaneous lesions may readily be overlooked by the medical consultant. Leprosy is not familiar to many of the profession, and it is not at all surprising that the disease is not recognized. There is no doubt that sporadic cases of leprosy are existent in most communities in this country, especially in large cities. In Mexico, Cuba and the Philippine Islands the disease is endemic, and no doubt other tropical countries have the same condition. With these facts before us, it is not at all unreasonable to expect to find cases of leprosy existing in the semi-tropical state of Florida. True, the disease is prevalent in certain cold climates, especially the Scandinavian countries; nevertheless, it is very frequently seen in the tropics.

With this preface, a brief history of a case presented for your consideration follows:

Patient A., age 18, referred by Dr. Stanley Erwin, of Jacksonville, born and raised in Key West, Fla., both parents American, one sister, age 14, but no brothers. All members of the immediate family alive and enjoy good health. The patient has had measles, mumps and whooping-cough, no history of any skin eruption other than the present involvement, denies venereal infection.

The first appearance of the present cutaneous lesions was noted by the patient five years ago, they began first on the lower extremities in small circular patches of a pale, at times reddish, hue, these gradually extending, and new ones developing on the arms. Later, the past year, lesions have appeared on the hands, face, neck, trunk and thighs, the older lesions have extended considerably.

The patient has had fairly good health, since puberty has increased in weight. With the exception of slight attacks of "biliousness and fever" during the past few years, he has had nothing to complain of.

Examination of the patient shows a number of small ring-like lesions on the trunk, some are very similar to trichophytosis (ring-worm), larger lesions are on the extremities, neck and face; on both hips and extending around and down the front of the thigh are two more or less symmetrical circinate plaques, the borders of these are serphiginous, sharply defined and of a dark reddish color, somewhat the color of a

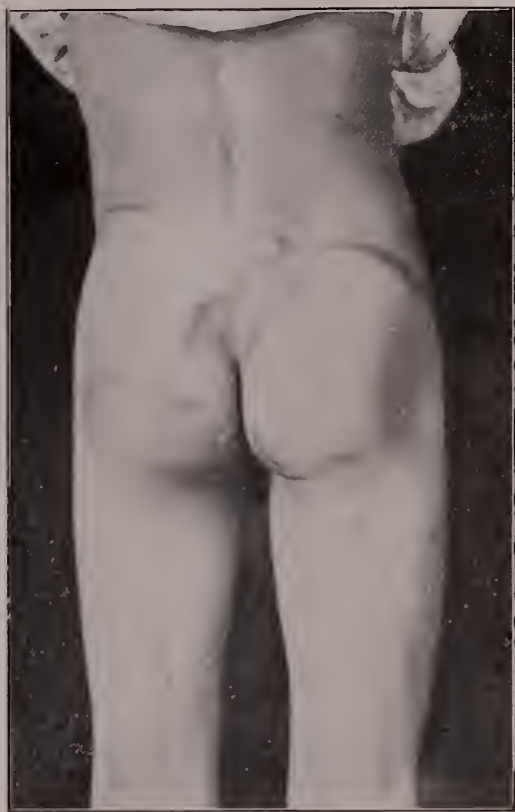


Fig. 2. Maculo-Anæsthetic Leprosy.

syphiloderm, the borders are continuous in each patch, forming girate lesions. As shown in the accompanying photograph, the skin in the inclosed patches have a pale or dull white appearance, at first sight it is of light bluish appearance, this characteristic is more marked by viewing the lesions at a distance, the dark borders are just perceptibly raised above the skin and this further accentuates the difference between the skin in and that surrounding the lesions. As previously men-

tioned, the small lesions are suggestive of trichophytosis, but scaliness is absent. On close examination with a hand magnifying glass the absence of grouped papules is noted as a differential point in the diagnosis of a circinate syphiloderm. When seen the patient had local treatment with chrysarobin ointment, with the characteristic stain on the clothes and skin, the lesions did not look unlike a cleared up psoriasis.

Attention is called to the fact that complete anæsthesia is present in the skin in all of the lesions, from the smallest circinate patch to the large girate lesions at the hips one can transfix the skin with a large needle without the slightest sensation of pain. The new lesions on the face and neck are more rightly called maculo-erythematous, having a pinkish to a dark red erythematous appearance. The ulnar nerve in both arms is enlarged, hardened, and is easily palpable.

Previously mentioned, the patient has had fairly good health, he has no particular complaint, he is fairly well nourished, heart, lungs and other organs apparently normal. There is no ulceration in the nasal mucosa. The Wassermann test was negative, the bacillus lepra was found in the serum from the skin in the spreading borders by Dr. Hanson.

A diagnosis of maculo-anæsthetic leprosy was made from the clinical appearance of the lesions and the anæsthesia present.

The patient was questioned as to his movements, associates, etc., with the idea of learning something of the source of the infection. The boy's father is with a steamship plying between Tampa, Key West, and Havana, Cuba; the patient has made a few trips with his father, but has not made an extensive stop in Cuba. There are quite a number of leprosy cases in Cuba and it was considered that this case had its origin there. The writer has a personal knowledge of several lepra patients from Key West, and this source was also considered. After seeing the patient several times and questioning him closely it was ascertained that the boy had a definite

idea as to his disease and knew positively where and when he was infected. It appears that a former playmate in Key West, whom he had slept with a number of times when he was younger, had at that time dark spots on his arms and legs that had no sensation in them when stuck with a pin. The patient later learned that his playmate was a leper, and when he developed similar spots with anæsthesia he came to the conclusion that he had the same disease as his former playmate. A boy of some intelligence, he naturally kept his discovery to himself, only recently his father noting the skin lesions, had directed him to Jacksonville for diagnosis and treatment.

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#### PROPAGANDA FOR REFORM.

GLYCEROPHOSPHATE COMP. AMPULS, 1 C. C., SQUIBB.—The Council on Pharmacy and Chemistry refused recognition to Glycerophosphate Comp. Ampuls, 1 c. c., Squibb, each said to contain sodium glycerophosphate 0.1 gm., strychnin cacodylate 0.0005 gm., and iron cacodylate 0.01 gm., because the name did not indicate the potent ingredients and because the administration of a mixture of sodium glycerophosphate, strychnin, cacodylate and iron cacodylate is irrational. In recognition of the Council's conclusion, Squibb & Sons state that the sale of the ampules has been discontinued. This cooperation in the work of the Council on Pharmacy and Chemistry is gratifying. (*Jour. A. M. A.*, Feb. 3, 1917, p. 388.)

SARGOL.—The case of the United States against Wylie B. Jones and H. E. Woodward, proprietors of "Sargol," came to an end January 30, 1917, after a trial lasting thirteen weeks. Jones was fined \$20,000, and Woodward was fined \$10,000. Sargol was a nostrum of the get-fat-quick variety; as an alleged "flesh builder" it was advertised extensively and intensively by its exploiters. (*Jour. A. M. A.*, Feb. 3, 1917, p. 381; Feb. 10, 1917, p. 468; Feb. 24, 1917, p. 642.)



APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

.....  
....., 191.....  
To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.

Sir :

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....  
.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country).....  
.....
4. When and where were you naturalized? (For applicants of alien birth only.).....  
.....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....  
.....
10. If either parent or brother or sister has died, state cause and age in each case:.....  
.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....  
.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc. :  
.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates : .....  
.....
16. With what ancient or modern languages or branches of science are you acquainted?.....  
.....

\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.

17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result: \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149

W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.

### Members of the Medical Officers' Reserve Corps in Training

Daily hikes of five miles length form part of the training of the doctor. Once a week they must camp out for the night. The illustration below pictures "the end of a perfect day", the soldier officers putting up their dog tents which are to furnish them shelter for the night.





**The Journal of the Florida Medical Association**

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or P. O. Box 136, Jacksonville, Fla., U. S. A.

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**Next Meeting — Tampa — May, 1918**

**THE PRESENT STATUS OF THE MEDICAL RESERVE CORPS, U. S. ARMY, AND ITS IMMEDIATE NEEDS.**

The impression seems to have gained ground in certain quarters that the present needs of the Surgeon General of the Army for additional officers in the Medical Reserve Corps are not pressing. We wish to emphatically correct this wrong impression and to say that the building up of the Medical Reserve Corps should not be allowed to suffer a slump until a full and efficient Reserve has been acquired. With what data is available at the time of writing, it is understood that the Surgeon General of the Army has about fifteen thousand medical officers available, this including the officers of the Medical Corps, the Medical Reserve Corps and the National Guard. Six months ago the Surgeon General stated that he would require twenty thousand officers for the care of the First army. From the figures quoted above it will be seen that the quota is still five thousand short of the required number. Is there anyone who believes for a single instant that our program for entering the war ceases with the equipment of our first army? Is it not plainly evident from statements appearing in the lay press that it is only a matter of a few weeks when additional men are to be called to the colors? Is it not plainly to be seen that large numbers of additional medical officers will be required for the care of this army? Indeed it is not unlikely that a third, fourth and additional increments will have to be called before peace once again settles over our land. While they doubtless mean well, the men who advocate the theory that peace will come within a few months are a dangerous class, especially when they hyphen with their theory that it is not necessary to make preparations for a long and continued struggle. Admit for the sake of the argument that it may be a short war, is that any reason why we should not make the necessary preparations for a long one? If peace should come

upon us unexpected it will not have done the individual any harm to have shown that he was ready to do his bit. A statement was recently circulated in Jacksonville that the Surgeon General had more medical officers than he knew what to do with. It is of course perfectly apparent to all who follow the situation that there is no ground for any such statement, but even were it so, there would be no harm done in having a Medical Reserve Corps of many thousands, in *Reserve*. During the present emergency the purpose of the creation of a Medical Reserve Corps has been more or less misinterpreted. Owing to the immense demands for active men in the field, all reserve corps men have been ordered to active duty almost immediately upon accepting their commissions. It is plainly evident that before the full object of the law, as applied to present needs, is attained that the Medical Reserve Corps should have thousands on the inactive list. Such would constitute a real reserve corps, the term "Reserve" literally applied is, under present conditions, a misnomer.

The Florida profession, as stated before in these columns, have no reason to be anything but proud of the manner in which the men have rallied to the colors. The fact that Florida stands well at the head of the list in the ratio of physicians to medical population offering their services in the Reserve Corps, should not be allowed to act as an excuse for additional men to hesitate in coming forward and doing their bit. We wish to keep Florida well at the head and this can not be done if every man who feels he can be spared from the community in which he lives, does not come forward and join the corps. We feel it not amiss to quote from editorials recently appearing in the columns of exchanges:

"Is your conscience quite clear that you are more needed at home than in the army? Are you quite sure of it? Can you go among your friends with your head high in the knowledge that everyone knows you are doing your full duty? These are searching questions, but so are these terrible times.

Choose ye now. He that can possibly go should make haste to enlist. Doctors can not be conscripted we are informed on good authority. Ask yourself not, 'If I do go, will I lose money by enlisting,' but, 'How can I arrange my affairs so that I may go?' Your country needs you, is calling you. Are you the man?" — *The Wisconsin Medical Journal*.

"The unparalleled demand for army physicians seems to indicate that a sufficient number will not be secured under the volunteer method. On a war-time basis, one physician is needed for 100 enlisted men. The Surgeon General's figures to date indicate that barely enough men have been secured to care for the first draft army of 687,000 men. As a second draft is in immediate prospect and as our field forces may be increased to two million men, a very material increase in the army medical force is imperative." — *The Ohio State Medical Journal*.

"How soon will the medical profession of the United States as a whole wake up and realize that doctors must come forward and volunteer their services to the government?"

"In civil life, when great casualties occur, the doctor readily offers his services and usually is the first on the scene to save human life. How much more important is it, then, that in this critical situation he should come forward and offer his valuable aid to preserve not only human lives but the life of the nation itself?" — *The Journal of the Medical Association of Georgia*.

"The response to the appeal for volunteers for the Reserve Corps has up to date been neither gratifying nor creditable." — *The Rhode Island Medical Journal*.

"Let there be no slacker. We dare have no slacker in this profession. It must lead and hold up the torch. Our philosophy has not failed and will not fail in this, civilization's greatest crisis in history. The challenging obligation of service comes today to the medical profession with the authority of an insistent demand. One out of five of us

must go to the army. The rest of us, if our loyal support is tendered, will allow no consideration of personal advantage or gain to hinder the one ideal now uppermost. This war must be won. To that end let every doctor do his bit, whether at home or at the front."—*California State Journal of Medicine*.

THE JOURNAL has at no time assumed by word or implication who of the Florida profession should go and who should remain. That, as we have stated before, is a matter for a man's own conscience. All that we wish to emphasize is the fact that there is still an urgent call for all available men to volunteer their services. At the present time, in the true sense of the word, we have no Reserve Corps; as soon as a man is ordered to active duty, he ceases to be a Reserve. It should be the aim of every medical organization to do its share toward building up a Medical Reserve Corps, so that even in the eventuality of the war lasting for years there will never be a dearth of medical men to care for our wounded soldiers. No Reserve officer need fear that the Government will call him out until there is an actual need of his services. We have elsewhere called attention to the fact that for the immediate present there will not be any great number of additional Medical Reserve officers ordered to active duty. This, however, should not be construed as an indication that there is no further need of medical men identifying themselves with the Reserve Corps. It is the hope of the writer that in the months to come the Medical Reserve Corps will have assumed such proportions that there will be many thousands of them on the inactive list, constituting a true Reserve ready and willing for any and all possible contingencies.

G. E. H.

#### MEDICAL RESERVE CORPS OFFICERS ON THE INACTIVE LIST.

The Surgeon General of the Army has issued a statement that his office is fre-

quently advised of recently appointed officers in the Medical Reserve Corps having immediately upon accepting their commissions, sold their homes, ceased civil practice and otherwise severed local connections. This action has of course been taken by the newly-appointed officer on the assumption that he would be immediately called to active duty. It will easily be understood that this action has resulted in great inconvenience to the individual and some considerable confusion to the office of the Surgeon General. The Surgeon General states that up to a short time ago it was possible to assign officers as rapidly as appointments were accepted, but that unless conditions materially change, while the services of every available medical officer will eventually be required, for some time to come very few officers will be called to active duty. The Surgeon General lays emphasis on the necessity of newly-appointed officers in the Reserve Corps continuing their civil practices until such time as their services are needed with our army. Assurance is given that ample time will be given all physicians to close up their private affairs; a notice of at least fifteen days and probably a longer one than this will be given all officers about to be ordered to the colors.

During the past summer in several instances medical officers were ordered to active duty with hardly any notice, this action on the part of the War Department was, however, owing to a military necessity. With the statement of the Surgeon General that it will be some time before any great number of additional officers are ordered to active duty, a large number of physicians in this state who have held back from entering the corps on account of their affairs being in such condition that it was practically impossible for them to pick up and leave on a few days' notice, may now make application for appointment with the assurance that there will be an interval of several months between the acceptance of their commission and the assumption of active military duty.



Florida, while well at the head of the list of states in the ratio of physicians to medical population having offered their services in the Reserve Corps, is still quite a number short of her full quota. It is understood that the middle of March or first of April is about the time a large additional number of medical officers will be required. It is the hope of *THE JOURNAL* that with these several months in which to arrange their private affairs, every physician in the state who can be spared from civil life will make application for appointment in the Medical Reserve Corps. It can not be impressed upon the medical profession too forcibly that it is imperative our Government mobilize all the resources and forces of this great country. The share the medical profession has to assume in this immense task is a large one, but one that she is not going to shirk. We are going to have a wonderful army, wonderfully equipped, and wonderfully well taken care of. The medical profession will always be proud of the part she is going to take in this stupendous conflict; let every available physician in Florida, between now and the first of next March, identify himself with the Medical Reserve Corps and show that he is ready to do his bit.

G. E. H.

#### ACTION OF DUVAL COUNTY MEDICAL SOCIETY IN ASSISTING FINANCING THE JOURNAL DURING THE PERIOD OF THE WAR.

At the regular monthly meeting of the Duval County Medical Society, held on Tuesday, November 6th, the organization voted to remit to the Florida Medical Association one dollar and fifty cents for every member of the organization absent on military duty, provided the State Association would accept this amount in lieu of the three-dollar annual assessment representing the state dues of the individual member and apply the full amount so received toward the maintenance of *THE JOURNAL*. It is not thought that any objection will be

raised to this arrangement at the next annual meeting of the State Association to be held in Tampa. The Florida Medical Association will have two hundred of its members on active military duty by the time the organization holds its next annual meeting. This number will be increased from time to time during the war, so that it is plainly evident that if *THE JOURNAL* is to be maintained during the war the action outlined above must be adopted at least by the larger county units throughout the state.

*THE JOURNAL* trusts that all the county societies that can afford to, will follow the precedent established by the Duval County Medical Society.

G. E. H.

#### HELPS TO THE SCOFFER AT FOOD VALUES.

It is often said that necessity is the mother of invention; but necessity is also a good teacher in many other ways. In times of plenty we may be oblivious to the needs of the moment, whereas we soon learn to count the cost when "every little helps." Only a short time ago the earnest student of nutrition and dietetics was perenially twitted with the humor of the man who smilingly insisted that he wanted food, not calories. But times have changed, and the jokes about book learning and scientific feeding are replaced by an earnest desire for education in the tenets of nutrition. As Professor Bevier<sup>1</sup> of the Department of Household Science at the University of Illinois has aptly expressed the situation, with the shortage of food and the demands for saving it, there has come even to the mind of "the people" their helplessness because of their ignorance of food values. The people are writing to Washington, to the agricultural colleges, to anybody and to everybody for help in saving food. In response to this demand a great variety of helps to the housewife are appearing. Mr. Hoover's instruction card and the government devices are variations of lessons in

1. Bevier, Isabel: An Experiment in Teaching Food Values, *Jour. Home Economics*, 1917, 9, 415.

food values. Every one understands perfectly that four quarters may take the place of one dollar in buying food, but many people can not tell how many eggs at 40 cents a dozen may be used to replace in food value round steak at 25 cents a pound, or how to substitute for a quart of milk. It is easy even now to see that the term "food value" is beginning to receive respectful attention, and that way lies the basis for wise buying of food. War tends to make kindred of men. We can forgive the erstwhile scoffer, and we urge him to satisfy his newly acquired curiosity as to food values by consulting a timely series of well edited bulletins on "How to Select Foods," which the United States Department of Agriculture has lately put at the disposal of the public without cost.<sup>2</sup>—*Journal American Medical Association*.

2. These are issued under the editorship of Caroline L. Hunt and Helen W. Atwater as *Farmers' Bulletins*. They are available for free distribution on postal card request to the Department of Agriculture at Washington.

## THE TREATMENT OF EPIDEMIC POLIOMYELITIS WITH SO-CALLED SPECIFIC HORSE SERUM.

The recent reports by Rosenow<sup>1</sup> and by Nuzum and Willy<sup>2</sup> on the treatment of epidemic poliomyelitis with the serum of immunized horses, for which excellent results are claimed, are of considerable interest. The horses were immunized with the coccus recently found by several observers in the central nervous system in epidemic poliomyelitis, and consequently the question of the exact relation of this coccus to poliomyelitis is again raised.<sup>3</sup> In both reports, it is asserted that the serum used has protective and curative powers with respect to the experimental poliomyelitis of the monkey

produced by means of poliomyelitis virus, that is, suspensions in physiologic sodium chlorid solution of fresh or glycerinated nervous tissue from human beings that have died with this disease, or from monkeys experimentally infected. While the coccus with which the horses were injected unquestionably occurs in poliomyelitis, and frequently may be present in the so-called virus, its exact relations to the disease have not been made fully clear because thus far it has not been possible to produce poliomyelitis in the monkey by injections of this coccus in undoubted pure culture. But in spite of the lack of this essential link in the chain of evidence necessary to establish that the coccus is the cause of the disease, it must be acknowledged that if the serum of horses immunized with the coccus protects against and even cures poliomyelitis in the monkey, an adequate experimental basis for a thorough trial of such serum in the treatment of the human disease certainly has been provided. It is clear, however, that the results of further experiments on the action of the serum in monkey poliomyelitis are required before the claims in favor of its protective and curative powers may be regarded as fully established. At this point it may be stated also that the assertion by Nuzum and Willy that a coccus quite like the one found in the central nervous system in poliomyelitis occurs regularly in the cerebrospinal fluid of poliomyelitis patients, not being in accord with the results obtained by other observers, can not yet be accepted without confirmation from other sources.

Turning now to a brief consideration of the recorded results from the use of serum produced as indicated, we find that Rosenow treated fifty-four patients with nine deaths, but that six of the patients that died were moribund when the serum was injected "and hence should not be included as treated cases." This would leave a death rate of 8 per cent. Sixteen of these patients were in the preparalytic stage, and all recovered. Of twenty-three patients in the same epidemic,

1. Rosenow, E. C.: The Treatment of Epidemic Poliomyelitis with Immune Horse Serum, *The Journal A. M. A.*, September 29, 1917, p. 1074.

2. Nuzum, J. W., and Willy, R. G.: Specific Serum Therapy of Epidemic Poliomyelitis, *The Journal A. M. A.*, October 13, 1917, p. 1247.

3. The Bacteriology of Poliomyelitis, editorial, *The Journal A. M. A.*, April 14, 1917, p. 1122.

nine died (35 per cent). The effects of the serum in the individual case are often striking, at least apparently, because the symptoms soon subside, paralysis, for instance, being arrested and sometimes disappearing completely if in the early stages. As rapid improvement may occur spontaneously in poliomyelitis, as the diagnosis in the pre-paralytic stage must be difficult (sixteen of the patients treated with recovery are said to have been in this stage), and as it is impossible to form any opinion whether the treated and untreated patients that were the subject of this report are fairly comparable, it evidently is necessary, as Rosenow himself says, that many more patients be treated before conclusions can be drawn as to the exact value of the serum he used.

Nuzum and Willy have treated 159 patients, eighteen of whom died (11.3 per cent). Of 100 untreated patients admitted during the same period of time to the same hospital, forty-five died (45 per cent). We lack, however, a more detailed comparison as to the ages, severity of attack and general condition of the patients composing the treated and untreated groups. We have no information whatever in regard to the principles of selection followed in forming these two groups; consequently it is difficult to determine how much importance may be assigned to the apparently very favorable figures given in this report. These observers also emphasize the rapid general improvement commonly seen after the injection of the serum, there being in many cases a critical drop of temperature.

In conclusion, it may be said that the injection of horse serum, in the manner described with detail in these two reports, appears to be quite harmless in poliomyelitis; that the authors of the reports are deeply impressed with the apparent good effects of the serum; that their figures appear to show a great reduction in the death rate, but that the figures are probably not to be accepted without the reservation that they may seem more favorable than is actually warranted.

Further observations will be awaited with much interest. We hope it may be found, and quickly, that a potent, specific anti-poliomyelitis serum, protective and curative, has been discovered. The suggestion may be ventured that even if it eventually should be found that serum produced as described in these reports has little or no specific effect on the essential cause of poliomyelitis, its use may be followed by favorable results due on the one hand to general nonspecific effects such as follow the intravenous injections of foreign proteins, and on the other hand to its action, specific in nature, on the coccus used in the immunization, which may be a secondary invader of no little importance in poliomyelitis. — *Journal American Medical Association*.

#### THE COST OF MARKET MILK.

*The Journal* has repeatedly directed attention in the past few months to the importance of maintaining unimpaired the milk supply and, if possible, increasing the production of milk in the United States in the present emergency. The reasons need not be reiterated here. The desirability of providing "a quart of milk a day" for every child is only one of the impelling circumstances for securing as much as possible of this food. In the past there have been few articles of diet which furnished so much quantitatively and qualitatively in the way of desirable nutrients in palatable form as a quart of milk at the prices current before the recent skyward tendency of costs. As there is great danger that consumption of milk will be much decreased, and since much unfavorable comment is already making itself felt, it is imperative that those vitally concerned, as is the physician in eminent degree, should understand the situation in its true light. If 10 to 15 cents per quart represented exceptionally high prices of milk before the war, it does not follow that they are in any sense exorbitant at the present time. Adequate calories can no longer be purchased at the rate of 20 cents per adult requirement.



per day. War means sacrifice that expresses itself in increased payment for service and materials in every direction. Economy is only one form of material sacrifice in war time. As part of its program the Connecticut Committee on Food Supply has just published studies from a survey on the cost of market milk production.<sup>1</sup> This deals with statistical facts rather than with exaggerated generalities bearing on the actual cost of producing milk under present conditions, that is, with the abnormal increase in prices for feed, labor and other items. After all, the dairy cow is no mysterious agency, but merely a machine, as it were, for converting one kind of food into another. The output and intake are correlated in cost, and the machine must be carefully managed. In typical communities in the Eastern United States, where the milk must be produced near to an immediate market, the cost of milk production on 178 representative dairy farms for the year ending April 30, 1917, was 5.53 cents per quart, or \$2.51 per hundred pounds. In April, 1917, however, the cost was 6.29 cents per quart, or \$2.92 per hundred pounds, with labor at the yearly rates. There is no profit in producing milk at the lower price. The cost per quart has advanced more rapidly than the increase in price received in the past few years. As the result of a census taken among 2,500 farmers there was shown a decrease in mature dairy stock for the year of 4.5 per cent and an increase in young stock of 6.7 per cent. There was a net decrease of all dairy stock of 1.6 per cent. This represents the conditions on farms remaining in the dairy business, where, through summer conditions and patriotic motives, they have been able to nearly maintain their herd numbers. This fall, with winter conditions ahead, if conditions appear to be the same as last year, many men will probably reduce their herds. This is one of the conditions that must be

averted if possible. A frank understanding of the situation will help in the impending emergency.—*Journal American Medical Association*.

### MEDICO-MILITARY JOTTINGS.

(THE JOURNAL will be pleased to receive items for publication in this column which commencing with this issue will become a regular feature.)

Lieutenant-Colonel Joseph Y. Porter, Medical Corps, United States Army, for many years our State Health Officer, has been assigned to Camp Johnston and will be in command of the medical forces at that point. The assignment is especially gratifying to his many friends in the Florida medical profession.

Past-President John MacDiarmid, Captain, Medical Reserve Corps, United States Army, has been called into active service and is stationed at Camp Greenleaf, Fort Oglethorpe, Ga.

Major Raymond C. Turck, Medical Reserve Corps, U. S. Army, has been appointed Sanitary Inspector at Camp Wheeler, Macon, Ga.

Major Ralph N. Green, National Guard, United States (Fla.), stationed at Camp Wheeler, was in Jacksonville the latter part of last month, en route to a point in the southern part of the state where he was called as an expert witness in an important murder trial.

Past-President Frederick C. Moor, Captain, Medical Reserve Corps, U. S. Army, was recently ordered to active duty and is stationed at Camp Greenleaf, Fort Oglethorpe, Ga. Tallahassee and the whole state of Florida is going to miss the genial Fred.

Captain Henry Hanson, Medical Reserve Corps, U. S. Army, was one of the first of the Jacksonville profession to be called away. He is stationed "Somewhere on the Canal Zone."

Passed Assistant Surgeon W. Pettus Dey, U. S. Naval Reserves, is still able to greet his friends in Jacksonville, being on duty in

1. Musser, K. B.; White, G. C.; McDonald, B. A., and Judkins, H. F.: Studies from the Survey on the Cost of Market Milk Production, Conn. Agr. College, Extension Service, Bull. 7, July, 1917.

his home city. Pettus would make a good sailor; it is rumored he will soon be in the making.

Major John E. Boyd, Medical Reserve Corps, U. S. Army, is said to be "some" Instructor. He is stationed at the Medical Officers' Training Camp, Camp Greenleaf, Fort Oglethorpe, Ga.

The many friends of Lieutenant H. F. Horne, Medical Reserve Corps, U. S. Army, will regret to learn that he was recently operated for appendicitis. He is now convalescent and stationed at Camp Wheeler, Macon, Ga.

The First Florida Field Hospital, under command of Major L. A. Green, National Guard, United States (Fla.), is making an enviable record at Camp Wheeler, Ga.

Captain Harry A. Peyton, Medical Reserve Corps, U. S. Army, has recently been ordered to Camp Jackson, Columbia, S. C.

Passed Assistant Surgeon J. Knox Simpson, U. S. Naval Reserves, is Chief of the Surgical Service, at the Naval Hospital, Charleston, S. C. It has been reported to THE JOURNAL that Knox took a walk through Charleston a few days after reporting for duty. He met so many rookies that a myentasis developed as a result of returning so many salutes. He now takes his exercise in the operating room.

Captain Joseph N. Fogarty, Medical Reserve Corps, U. S. Army, recently stationed at Camp Greenleaf, has been honorably discharged from the Medical Reserve Corps.

Lieutenant Theodore G. Croft, Medical Reserve Corps, U. S. Army, is reported as recently having arrived at an English port; it is believed that he is now "Somewhere in France."

Captain S. M. R. Kennedy, Medical Reserve Corps, U. S. Army, was one of the first of West Florida physicians to arrive on the other side. He also is "Somewhere."

Assistant Surgeon Thomas S. Field, U. S. Naval Reserves, accompanied the first torpedo-boat flotilla sailing for the other side. Tom is very fond of the water and

writes his friends that he is seeing plenty of it.

Captain W. J. Buck, National Guard, United States (Fla.), is stationed at Camp Wheeler, Macon, Ga.

Officers in the military and naval services desirous of receiving THE JOURNAL are urged to send in their addresses. It is practically impossible to keep our mailing list corrected up to date as officers are changing stations frequently. The enormous amount of mail addressed in care of the authorities at Washington makes it impracticable for them to accept, for forwarding purposes, any mail matter other than first class.

There are several bills to come before Congress when it convenes next December in the interest of the medical officer. Among them may be mentioned at this time the Owen amendment to the National Defense act, providing increased rank for the medical officer, and a bill providing that commutation of quarters be allowed all officers serving in the field with troops, having families at home, not occupying public quarters. This is a matter probably not thoroughly understood by newly-appointed officers. Under the present law, when an officer is on detached duty, or when he is on duty where public quarters can not be provided, he is allowed a cash commutation for quarters, light and heat. In the case of an officer with the rank of Major it amounts to approximately sixty-five dollars a month, to a Captain fifty-five dollars, and to a First Lieutenant forty-three dollars. Prior to the present war, quarters were available for all officers' families, whether the officer was stationed where he could have his family with him or not. With the enormous increase in our army it is not practical to furnish quarters to officers' families. The so-called New amendment, introduced at the special session of Congress just adjourned, sought to give relief to the present unfair status of the government being unable to provide quarters for officers' families or able under existing laws to allow

commutation therefor when the officer is on duty with troops and himself occupying public quarters. Through, what we believe to be a misunderstanding, or lack of information on the subject, the amendment was defeated at the special session. It is to come up again when Congress convenes next month, and is understood now to have the endorsement of the Senate Committee on Military Affairs. In the meantime it would be well for all friends of members in the services to write their representatives in the Senate and House urging them to support both the bills referred to above. It is against the rules of the service for any officer to urge the passage of pending legislation promoting his interests. It therefore behooves the medical man to see what he can do to help his medico-military confrère.

#### FLORIDA PHYSICIANS IN MEDICAL RESERVE CORPS, U. S. ARMY.\*

In the September number of *THE JOURNAL* we published a list of Florida physicians recommended by the Surgeon General of the Army for appointment in the Medical Reserve Corps. The following names comprise those who have been recommended by the Surgeon General for appointment since the publication of our former list:

<i>Name and Home Address.</i>	<i>Rank.</i>
Cecil Hendry Wilson, Bartow.....	1st Lieut.
George Elliott Atwood, Boca Grande.....	Captain
Murdoc Lee Grum, Bowling Green.....	Captain
Necy Lewis Gachet, Century .....	1st Lieut.
John Samuel Turbeville, Century.....	Captain
Joseph Max Irwin, Crystal River.....	Captain
Thomas Edwin Parrish, Dania.....	1st Lieut.
Robert Fairleigh McDaniel, DeLand ....	1st Lieut.
John R. Hereford, Fort Dade.....	Major
Grover Cleveland Hardie, Ft. Pierce.....	1st Lieut.
James Lee Pennington, Fountain.....	1st Lieut.
Herbert Arent McClure, Greenwood.....	1st Lieut.
William E. Sherman, Haines City.....	1st Lieut.
Shores E. Clinard, Jacksonville.....	1st Lieut.
Robert Drysdale May, Jacksonville.....	1st Lieut.
Harper Lane Proctor, Jacksonville.....	1st Lieut.
Howard Crawford VonDahm, Jacksonville, 1st	Lieut.
Thomas Henry Bates, Lake City.....	1st Lieut.
Thomas W. Witt, Lake City .....	1st Lieut.
William Benjamin Moon, Lakeland.....	Captain
Grover Cleveland Franklin, Larkins.....	1st Lieut.
Eustace Long, Madison .....	1st Lieut.

Thomas Luther Lowrie, Miami.....	1st Lieut.
John L. Adams, Milligan .....	1st Lieut.
Robert Hardy Trammell, Muscogee.....	1st Lieut.
Walter Philip Dickinson, Nichols .....	1st Lieut.
Robert Francis McLeod, Otter Creek.....	1st Lieut.
Walter Heron Hatfield, Pass-a-Grille.....	1st Lieut.
Edward Flynn Aarons, Jr., Pensacola....	1st Lieut.
Charles V. Smith, Pensacola .....	1st Lieut.
Thomas Albert Neal, Sanford .....	Captain
Jacob John Spencer, St. Augustine.....	1st Lieut.
Moreton Homer Axline, St. Petersburg....	Captain
Odus Gilben Kendrick, Tallahassee.....	1st Lieut.
Raymond B. McLaws, Tampa .....	Captain
Lyston Hull D. Pierce, Tampa .....	Captain
J. Brown Wallace, Tampa .....	Captain
Harvey Otis Byrd, Trilby .....	1st Lieut.

#### OUR HONOR ROLL.

Our Honor Roll as published below now constitutes a grand total of one hundred and forty-four physicians. They are divided in the services as follows: Medical Corps—Lieutenant Colonel, 1; Medical Reserve Corps—Majors, 4; Captains, 25; 1st Lieutenants, 100; total, 130. United States Navy—Passed Assistant Surgeons, 2; Assistant Surgeons, 3; total, 5. National Guard United States (Fla.)—Majors, 3; Captain, 1; 1st Lieutenants, 5; total, 9. The list is gradually becoming complete; we urge all to help us maintain it in a thorough manner.

#### MEDICAL CORPS, U. S. ARMY.

<i>Home Address.</i>
Lieut.-Colonel Joseph Y. Porter.....Key West
MEDICAL OFFICERS' RESERVE CORPS.

Major Frank E. Artaud.....	Key West
Major John E. Boyd .....	Jacksonville
Major Chauncey L. Chase .....	Fort Dade
Major Raymond C. Turck .....	Jacksonville
Captain Frederick G. Barfield .....	Jacksonville
Captain E. G. Birge .....	Jacksonville
Captain H. O. Black .....	Jacksonville
Captain Andrew R. Bond .....	Tampa
Captain Joseph N. Fogarty .....	Key West
Captain Albert H. Freeman .....	Starke
Captain James B. Griffin .....	St. Augustine
Captain J. Halton .....	Sarasota
Captain Henry Hanson .....	Jacksonville
Captain H. H. Harris .....	Jacksonville
Captain Graham E. Henson .....	Jacksonville
Captain Frederick E. Jenkins .....	Palatka
Captain Owen H. Kenan .....	Palm Beach
Captain S. M. R. Kennedy.....	Pensacola
Captain Frank R. Maura .....	Ojus
Captain William W. Mills .....	Miami
Captain William B. Moon .....	Lakeland
Captain Frederick C. Moor .....	Tallahassee
Captain John MacDiarmid .....	DeLand
Captain D. W. McMillan .....	Pensacola
Captain Thomas A. Neal.....	Sanford

\*Corrected to October 12th.



Captain James D. Pasco .....	Jacksonville	1st Lieut. Charles L. Jennings .....	Jacksonville
Captain Harry Peyton .....	Jacksonville	1st Lieut. Charles L. Kennon .....	Jacksonville
Captain M. B. Swift .....	Orlando	1st Lieut. Alpheus C. Koon .....	Jacksonville
Captain Harry F. Watt .....	Ocala	1st Lieut. William J. Lancaster .....	Tampa
1st Lieut. A. E. Acker .....	Jacksonville	1st Lieut. Richard Leffers .....	Lakeland
1st Lieut. Daniel M. Adams .....	Panama City	1st Lieut. John P. Long .....	Lake City
1st Lieut. Allen M. Ames .....	Pensacola	1st Lieut. John W. McClane .....	St. Petersburg
1st Lieut. C. A. Andrews .....	Tampa	1st Lieut. George S. McClellan .....	Wellborn
1st Lieut. Walter J. Baker .....	Loughridge	1st Lieut. James A. McEachren .....	Monticello
1st Lieut. Harold M. Beardall .....	Orlando	1st Lieut. Harry B. McEuen .....	Quincy
1st Lieut. Henry P. Bevis .....	Arcadia	1st Lieut. William G. McKay .....	Jacksonville
1st Lieut. James H. Bickerstaff .....	Pensacola	1st Lieut. R. B. McLaws .....	Tampa
1st Lieut. Everard Blackshear .....	Citra	1st Lieut. Earle H. McRae .....	Tampa
1st Lieut. Louis B. Bouchelle .....	DeLand	1st Lieut. John D. McRae .....	Tampa
1st Lieut. John T. Bradshaw .....	San Antonio	1st Lieut. H. R. Mills .....	Tampa
1st Lieut. Percy H. Brigham .....	Branford	1st Lieut. George M. Mitchell .....	Jacksonville
1st Lieut. Herbert L. Bryans .....	Pensacola	1st Lieut. Joseph A. Mixon .....	Pensacola
1st Lieut. B. A. Burks .....	Titusville	1st Lieut. H. P. Newman .....	Bartow
1st Lieut. Fay A. Cameron .....	Tampa	1st Lieut. John A. Newnham .....	Cleremont
1st Lieut. T. Z. Cason .....	Jacksonville	1st Lieut. John K. Norwood .....	Jacksonville
1st Lieut. Chauncey L. Chase .....	Fort Dade	1st Lieut. Bascom H. Palmer .....	Tampa
1st Lieut. Joseph H. Chiles .....	Cleremont	1st Lieut. Henry E. Parnell .....	Fort Myers
1st Lieut. William A. Clark .....	Pine Barren	1st Lieut. James B. Parramore .....	Jacksonville
1st Lieut. J. S. Coker .....	Gardner	1st Lieut. Archie R. Parrott .....	Jacksonville
1st Lieut. Henry B. Cordes .....	Jacksonville	1st Lieut. James L. Pennington .....	Fountain
1st Lieut. Herbert W. Counts .....	Ocala	1st Lieut. J. O. Philips .....	Worthington Springs
1st Lieut. Charles S. Cooper .....	St. Cloud	1st Lieut. William H. Pickett .....	Gainesville
1st Lieut. Wallace P. Crigler .....	Ocala	1st Lieut. Marion E. Quina .....	Pensacola
1st Lieut. T. G. Croft .....	Jacksonville	1st Lieut. Shaler A. Richardson .....	Jacksonville
1st Lieut. Clinton W. D'Alemberte .....	Pensacola	1st Lieut. Dwight M. Rivers .....	Lake City
1st Lieut. James S. Davidson .....	Clearwater	1st Lieut. E. T. Sellers .....	Jacksonville
1st Lieut. Kenneth McC. Davis .....	Westbay	1st Lieut. George W. Sherouse .....	Campville
1st Lieut. Gaston Day .....	Jacksonville	1st Lieut. E. E. Strickland .....	Miccosukie
1st Lieut. L. B. Dickerson .....	Clearwater	1st Lieut. Baldwin S. Stutts .....	Port St. Joe
1st Lieut. George W. Dupree .....	Blue Creek	1st Lieut. G. C. Tillman .....	Gainesville
1st Lieut. Lester J. Efrid .....	Tampa	1st Lieut. W. J. Vinson .....	Tarpon Springs
1st Lieut. William T. Elmore .....	Gainesville	1st Lieut. Adam C. Walkup .....	McIntosh
1st Lieut. Stanley Erwin .....	Jacksonville	1st Lieut. Archie Watson .....	Live Oak
1st Lieut. Orin O. Feaster .....	Mulberry	1st Lieut. B. L. Whitten .....	Fort Pierce
1st Lieut. Neco L. Gachet .....	Century	1st Lieut. John M. Whitfield .....	Malone
1st Lieut. Harry C. Galey .....	Key West	1st Lieut. William E. Whitlock .....	Fort White
1st Lieut. Julian Gammon .....	Jacksonville	1st Lieut. Charlton C. Whittle .....	Nocatee
1st Lieut. Claude V. Gautier .....	Passagrille	1st Lieut. Daniel B. Williams .....	Lake City
1st Lieut. Hugh St. C. Geiger .....	Kissimmee		
1st Lieut. H. M. Ginsberg .....	Pensacola		
1st Lieut. Paul Goss .....	Mulberry		
1st Lieut. O. F. Green .....	Mayo		
1st Lieut. John D. Griffin .....	Lakeland		
1st Lieut. J. H. Hall .....	Sopchoppy		
1st Lieut. John Halliday .....	Tampa		
1st Lieut. Drew R. Handley .....	Jacksonville		
1st Lieut. MacMiller Harrison .....	Palmetto		
1st Lieut. Maurice E. Heck .....	St. Augustine		
1st Lieut. John R. Hereford .....	Fort Dade		
1st Lieut. Frank P. Hixon .....	Pensacola		
1st Lieut. John C. Holley .....	Pace		
1st Lieut. Samuel G. Hollingsworth .....	Bradentown		
1st Lieut. H. F. Horne .....	Jacksonville		
1st Lieut. Roy Howe .....	Daytona		
1st Lieut. A. L. Izlar .....	Ocala		
1st Lieut. Edward Jelks .....	Jacksonville		

## THE NAVY.

Passed Assistant Surgeon W. P. Dey .. Jacksonville  
 Assistant Surgeon Thomas S. Field .... Jacksonville  
 Assistant Surgeon Boyd Gilbert ..... Pensacola |

Passed Asst. Surgeon J. Knox Simpson, Jacksonville  
 Assistant Surgeon D. C. Thompson ..... Pensacola |

## NATIONAL GUARD UNITED STATES (FLA.).

Major Lorin Green ..... Jacksonville || Major Ralph Green ..... | Jacksonville |
Major James H. Livingston .....	Jacksonville
Captain W. J. Buck .....	Gainesville
1st Lieut. Daniel C. Campbell .....	Marianna
1st Lieut. John R. Hawkins .....	Williston
1st Lieut. Z. V. Johnson .....	Milton
1st Lieut. Lucien B. Mitchell .....	Tampa
1st Lieut. J. M. Mitchell .....	Millville

## Cancer Department

"In the early treatment of cancer lies the hope of cure"

AMERICAN SOCIETY FOR THE CONTROL OF CANCER

### CANCER DECALOGUE.

The following Cancer Decalogue was recently prepared by the Standing Committee on the Control of Cancer of the Massachusetts Medical Society for publication in the Boston Medical and Surgical Journal:

1. *The Classical Signs of Cancer* are the signs of its incurable stages. Do not wait for the classical signs.

2. *Early Cancer causes no pain.* Its symptoms are not distinctive but should arouse suspicion. Confirm or overthrow this suspicion immediately by a thorough examination and, if necessary, by operation. The advice "Do not trouble that lump unless it troubles you" has cost countless lives.

3. *There is no sharp line between the benign and the malignant.* Many benign new growths become malignant and should therefore be removed without delay. All specimens should be examined microscopically to confirm the clinical diagnosis.

4. *Precancerous stage.* Chronic irritation is a source of cancer. The site and the cause of any chronic irritation should be removed. All erosions, ulcerations, and indurations of a chronic character should be *excised*. They are likely to become cancer.

5. *Early Cancer* is usually curable by radical operation. The early operation is the effective one. Do not perform less radical operations on favorable cases than you do on unfavorable ones. The chances for a permanent cure are proportionate to the extent of the first operation. Make wide dissections; incision into cancer tissue in the wound defeats the object of the operation and leads to certain local recurrence.

6. *Late Cancer* is incurable though not

always unrelievable. Radium, X-rays, ligation, cautery, or palliative operations may change distress to comfort and may even prolong life.

7. *Cancer of the Breast.* All chronic lumps in the breast should be removed without delay. Benign tumors can be removed without mutilation. Examine all specimens microscopically. An *immediate* microscopical examination is desirable since, if positive, it permits a radical operation at the same sitting. A radical operation performed ten days after an exploration is almost never successful in curing Cancer of the Breast.

8. *Cancer of the Uterus.* Any irregular flowing demands thorough investigation. Offensive or even very slight serous flows are especially suspicious. Curette and examine microscopically. Amputate all eroded cervixes which do not yield promptly to treatment. Do not wait for a positive diagnosis.

9. *Cancer of the Digestive System* is difficult of early diagnosis and therefore unfavorable in prognosis. All persistent and recurring indigestions (more especially if attended by change of color and loss of weight) and any bleeding or offensive discharges demand prompt and thorough investigation. Do not wait for a positive diagnosis.

10. *Cancer of the Skin.* Any warts, moles or birthmarks which enlarge, change color, or become irritated should be removed promptly. They are likely to become cancer. Do not wait for a positive diagnosis.

This Decalogue is an admirable summary of the whole subject and it is recommended by the Cancer Society to all medical journals for publication as often as possible.

## THE DOCTOR'S CONTRIBUTION.

In this world's war your service is absolutely essential.

The medical officer bears the same relative position in war as in peace in that he is a conservator of health and life.

Through his skill, thousands of men receiving slight casualties are returned to the fighting force, thus conserving the physical strength of the army.

In Base, Field and Evacuation hospitals doctors are as essential as in civil institutions, where the sick and injured are cared for.

As regimental surgeons and on transports and in the Sanitary Corps must the Government have doctors if we are to terminate this war successfully.

Your contribution to your country at this critical time is *your service* which you can give for the period of the war as an officer in the Medical Reserve Corps. That your country needs you is best answered in that she is calling you *now*.

The fighting forces are constantly expanding and such expansion calls for additional doctors and even with the troops now in training and under mobilization (about two million) the Surgeon General has not enough doctors to fill the requirements.

Secure an application blank at once; fill it out and present it to your nearest Examining Board. Do not live to regret that you did not have a part in your country's great struggle for democracy which means *Liberty*.

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#### CANADA'S WAR EXPERIENCE WITH TUBERCULOSIS.

Jabez H. Elliott, of Toronto, Ontario, in a paper read before the thirteenth annual meeting of the National Association for the Study and Prevention of Tuberculosis, printed in the July number of the American Review of Tuberculosis, discusses Canada's war experiences with tuberculosis. As a result of the rapid mobilization of a rela-

tively large volunteer body of soldiers new problems in the medical service and new aspects of old problems have been constantly arising. The militia organization has had to be developed until it was upon a war basis.

Men accepted for military service should be medically fit, or they become a source of weakness. Men becoming unfit after entering the service are a burden to the country because they are removed from productive activities, are an expense while in training and during the subsequent indefinite time of disability.

Preventive measures have been vastly improved since the Spanish-American War. Of almost 70,000 casualties in the Canadian forces up to February, 1917, only 518 died of infectious diseases. With relation to tuberculosis, preventive measures are essential. All applicants who are or have been tuberculous must be refused. Those passing the preliminary examination are re-examined by a medical board of three, one of whom should have special knowledge of diseases of the chest. Doubtful cases may, as an alternative, be referred to a chest clinic, civil or military. After joining the units, the men are carefully watched by the battalion medical officer and should have a careful routine examination every three months. Before sailing a most thorough medical examination is essential. Men not fit for combatant service may be fit for non-combatant duties. Sometimes a man drafted for the latter may improve and become fit for the first class.

Under selective conscription the whole problem is simplified. By simultaneous training of a whole battalion excessive fatigue is avoided, whereas under the volunteer system recruits may be added for a period of many months, and the later comers break under a training for which the recruits of longer standing are entirely fit. Whatever is done to lessen acute respiratory infections in camp will lessen the incidence of tuberculosis. These are frequent in the



large draughty barn-like structures used during the winter, but very infrequent in the summer camps of small tents or huts accommodating only from eight to thirty men each. Epidemics are more easily controlled in the latter. An outbreak of measles in a military hospital or camp is followed by an increased number of cases of tuberculosis. Sanitation in general bears indirectly upon the incidence of tuberculosis.

Of tuberculosis patients two classes are being returned to Canada from England, those quite convalescent and those hopelessly ill, to be sent to the military district from which they were enlisted. They are cared for in sanatoria that are exclusively for the military, and in those that care for the civilian patients as well. Soldiers should be cared for in their own district. Existing institutions should be utilized as far as possible with such additions as may be necessary. In addition a general military sanatorium should be established, supplied with facilities for vocational training and a farm colony for suitable cases. There should be institutions for the care of non-tuberculous pulmonary cases, many of which require special care and improve remarkably under suitable pulmonary exercises. A large number come home as tuberculous suspects in whom, on careful examination, definite tuberculosis is found.—Elliott, Jabez H.: *Am. Rev. Tub.*, 1917, i, 5, 267.

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#### UNITED STATES FOOD ADMINISTRATION.

The United States Food Administration announces the creation of an Advisory Committee on Public Health. This committee has been created because the Food Administration, realizing that the nutrition of a people and the condition of its food supply bear intimate relations to the general problems of public health, sought the advice of experts in these lines. Dr. Welch has been named as chairman of the committee, the personnel of which is as follows:

Leonard P. Ayer, Herman Biggs, David T. Edsall, Cary T. Grayson, A. Walter Hewlett, T. T. Janeway, F. G. Novy, Richard M. Pearce, William H. Welch, and H. Gideon Wells.

Dr. Ayer is permanently identified with the school hygiene movement. He has been director of the Department of Child Hygiene, Education, and Statistics of the Russell Sage Foundation during the past ten years; and is the author of books and articles on the educational and statistical phases of health work.

Dr. Biggs is a member of the Rockefeller Institute and an authority on public health and sanitation. As a representative of the Rockefeller Foundation, Dr. Biggs has recently completed a survey of the health conditions of France, with particular reference to tuberculosis.

Dr. Edsall is Professor of Internal Medicine in Harvard University; he has in the past devoted much effort to the investigation of nutritional diseases and within recent years has become identified with research in the general domain of industrial diseases, which bear to nutritional diseases, both in the individual and society, a close relationship.

With the creation of a large army and navy, the public service has a natural relation to the work of food control, and to represent the interests of the armed services of our country, Admiral Cary T. Grayson has been placed upon the Advisory Committee.

Dr. Hewlett is Professor of Internal Medicine in Stanford University and is a recognized authority on the subject of diseases of the circulation and elimination.

Dr. Janeway is Professor of Internal Medicine in Johns Hopkins University; he is the author of books and articles on diseases of circulation and elimination.

Dr. Novy is Professor of Bacteriology in the University of Michigan and through years of active research over the broadest

domains of his subject has established himself as an authority upon the subject of general sanitation.

Dr. Pearce is Director of the Department of Research Medicine in the University of Pennsylvania. Dr. Pearce has paid particular attention to the subject of national health and sanitation and has during the past two years, as a representative of the Rockefeller Foundation, completed surveys of the conditions of health and sanitation of Brazil and the Argentine Republic, at the requests of the governments of those countries.

Dr. Welch, Professor of Pathology in Johns Hopkins University, is scientifically and personally regarded universally as the dean of the American medical profession. There are a few departments of pathology to which Dr. Welch has not contributed in research; and there are no departments connected with public health upon which he had not impressed the influence of his wisdom and experience.

Dr. Wells is Director of the Sprague Memorial Institute of the University of Chicago, a research institution devoted to the investigation of diseases of constitutional type. Dr. Wells is the author of a very successful work on chemical pathology, the first of its kind in any language, and has contributed important research to many subdivisions of medical science.

It is believed that through the advice and cooperation of this committee, representing specialized workers in the various correlated departments of medicine, the administration of food control will be enabled always to work for the best interests of the health of the different classes in different sections of our country.

In addition Dr. Alonzo E. Taylor and Dr. Ray Lyman Wilbur, members of the Food Administration, will be ex-officio members of the committee.

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#### LITTLE PURE ZINC OXIDE ON THE MARKET.

Examinations made by the Bureau of

Chemistry of the United States Department of Agriculture show that very little zinc oxide on the market in the United States complies with the standards of the U. S. Pharmacopœia. Nearly all of the samples examined contained an excessive amount of lead. The samples were labeled "Not U. S. P.—Containing Small Quantities of Lead," and therefore complied with the Food and Drugs Act. The labels on the packages in most instances will probably come to the attention of the druggists, but not to the attention of physicians. The medical profession will therefore not be advised as to whether or not zinc oxide preparations are made from standard ingredients. Conditions may arise where a zinc oxide preparation contaminated with lead may do injury. A limited supply of U. S. P. zinc oxide is available and physicians may protect themselves and their patients from possible injury by calling for such material on their prescriptions.

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#### DEATH OF REVERE OSLER.

In announcing the death of Sir William Osler's only son in the issue for September 8, *The Journal* stated that Revere Osler had been wounded while on active duty in France, and was taken to England for treatment, where he died. Recently Dr. D. L. Moore of Columbus, Ohio, sent to *The Journal* a quotation from a letter dated September 21 written by a nurse in one of the American hospital units in France. She said: "One of the saddest things that happened during our stay in Belgium was the death of Sir William Osler's only son. He was brought to our station one night with a bad chest wound, a perforating wound in the intestines, and an injured thigh. Drs. Brewer and Darracks got Dr. Crile, who was in a station back of us, and also Dr. Harvey Cushing, who was near, in consultation. Major Darracks, with whom I worked, did the operating, Major Brewer assisting, Dr. Crile giving a direct blood transfusion, and Dr. Cushing consulting generally. Everything was done that could

have been done in any hospital, but the boy died several hours later. He was in the Royal Field Artillery service." A letter has just been received from Sir William Osler, dated Oxford, October 7, from which we quote: "My son Edward Revere was wounded in the chest and abdomen by a shell August 29, was taken to the Casualty Clearing Station, at which my good friends George Brewer, of New York, and George Crile were stationed. Darrack, of New York, operated and Crile transfused. His

life-long friend Harvey Cushing was also with him. Everything possible was done, but he died about twenty hours later. Many of my friends would be glad to know of this." It is gratifying to the thousands of American friends of Sir William Osler that when his son was mortally wounded the best medical and surgical skill was available, and especially that this skill rested in old-time American friends of both the father and the son.—*Journal American Medical Association*.

## Reviews from Current Literature

### PROSTATECTOMY

Judd, Edward S.: Prostatectomy. *Interstate Medical Journal*, 1917, Vol. XXIV, p. 793.

This author states that ordinary prostatic hypertrophy is a series of neoplasms which compress the glandular portions between the new growth and capsule. This is found in 60 per cent of all men over fifty years of age. Especial attention is given to symptoms of retention and disability to empty the bladder. It is probable that residual urine causes systemic metabolic changes which are serious or fatal when suddenly relieved. It is explained that residual urine causes a very gradual back pressure to the kidney. The operation suddenly relieves the pressure and the negative pressure causes hypertension of blood vessels of the kidney, producing acute congestion, which results in many cases in an acute nephritis. The author has attempted to give urinary constituents to counteract these toxic symptoms which develop, but has had little success. The patient presents similar symptoms seen in the morphine addict when the drug is suddenly withdrawn. A plea is made for the two-stage treatment of all prostatic conditions. In the first stage treatment is instituted by daily catheterization followed by twice and three times a day irrigation until urine is pus free and a normal specific gravity has been restored. This is an important index to the patient's general

condition. Sudden relief from urinary retention is usually accompanied by an acute drop in the specific gravity, loss of appetite, vomiting, and sometimes uræmia. This period may last one or two weeks. At the end of this time the patient feels well, usually better than he has felt in years. Irrigation through the urethra is advocated in all cases where this is possible. Suprapubic irrigation is to be done only in cases of extreme stricture or pressure, since we have the added danger of infection and reaction from this. At the end of two or three weeks the ordinary operation for prostatectomy is done and with practically no mortality.

F. J. B.

### NEPHRITIS

Ophuls, William: The Etiology and Development of Nephritis. *Journal American Medical Association*, Vol. XXXIX, 1917, p. 1223.

The author is of the opinion that from an etiologic and anatomic viewpoint the various forms of nephritis (chronic parenchymatous, chronic interstitial, arteriosclerotic) are mere different manifestations of the more applicable glomerulonephritis. That it is of bacterial origin, the principal offending organism being the streptococcus, although others may be convicted. He discusses the acute, subacute and chronic forms of the disease from a pathologic standpoint and concludes that there is a well-defined



disease of the kidneys caused by general sepsis from some infected focus: since the glomeruli show the most characteristic and constant lesions, glomerulonephritis is the more applicable term: the characteristic lesions may be produced in animals by the injection of bacteria into the blood stream, and that diseased tonsils offer a focus of infection in many cases.

R. H. M.

### MIGRAINE

Einhorn, Max: *Migraine and Chronic Intestinal Stasis, Their Relationship and Treatment.* Journal American Medical Association, Vol. XXXIX, 1917, p. 1315.

The author discusses the symptoms from the nervous and intestinal manifestations and shows their interrelations, observing that constipation exists to a high degree in the insane, and those who are highly nervous have their constipation increased by the nervous condition. Under etiology and treatment he emphasizes the proper qualities and quantities of the diet, the amount of rest and exercise the patient should take, the removal of fear in the patient's mind of accumulative material and absorption therefrom in the intestinal canal, and the use of mild laxatives and cathartics in order that a movement of the bowel become a habitual act every day at a certain and regular period. He finds the removal of the colon by operation unjustifiable except in proven pathology of this organ.

R. H. M.

### INTESTINAL TOXEMIA

Satterlee, G. Reese; Eldridge, Watson W.: *Symptomatology of the Nervous Symptoms in Chronic Intestinal Toxemia.* Journal American Medical Association, Vol. XXXIX, 1917, p. 1414.

The authors studied 518 cases and divide the symptomatology into four classes: (1) Mental system; (2) sensory system; (3) motor system; (4) sympathetic system. The symptoms may occur separately or in combination, usually the latter. The authors report five case histories, diagnosis and treatment illustrative of the particular part of the nervous system involved, concluding: The nervous system is almost invariably

affected in whole or in part by chronic intestinal toxemias. The nervous symptoms are often the most prominent in the symptomatology. Disturbances of the gastrointestinal system are more often the cause of a nervous symptomatology than the result of a diseased nervous system. In doubtful cases a proper hygiene and therapy of the intestinal tract will often be the deciding factor in differential diagnosis.

R. H. M.

### VESICO-VAGINAL FISTULA

Frank, Robert T.: *The Principles Governing the Spontaneous Repair and Operative Closure of Vesico-Vaginal Fistulae.* Surg., Gyn. and Obst., Nov. 1917, Vol. XXV, p. 538.

The author's report is based upon 22 cases admitted to the First Gynecological Service of Mt. Sinai Hospital. After considering the various methods of operation and his own technique, Frank makes the following summary:

Comparison of those cases of bladder injury which heal spontaneously with those which form permanent fistulae shows that neither the size nor situation of the defect is of as much importance as the fact that in the former the bladder is free to contract and that broad tissue planes are mobilized.

By applying these observations to operative repair, more uniformly successful results may be anticipated. Full liberation of the bladder should be practiced in every case before attempting to repair the injury. This injunction should be obeyed especially by the occasional operator who is not intimately acquainted with the minute and precise technique of the Sims and the flap-splitting operation.

With slight variations the above method is applicable alike to simple fistulae, inaccessible fistulae, or fistulae complicated by partial or complete destruction of the bladder sphincter. When the sphincter is completely destroyed, plastic construction of a new urethra proves unsatisfactory. After the repair of the defect the uterus may be interposed into the vesico-vaginal septum to restore continence.

Depending on the local conditions encountered, the vaginal, suprapubic, or combined method of approach may be practiced.

When a leak develops, the use of the permanent catheter should be persisted in far longer than is customary. Healing may still take place as late as the fourth week.

By fully liberating the bladder as a matter of routine, diverticula can not escape notice.

G. R. H.

#### OATMEAL GRUEL IN INFANT FEEDING

Levison, A.: Oatmeal Gruel in Infant Feeding. *Archives of Pediatrics*, Vol. XXXIV, 1917, p. 707.

The fat in oats, besides being higher in percentage, is better in quality than that contained in other grains. The iron content is also high.

The most valuable preparation of oats in the feeding of sick or healthy children is an oatmeal gruel of the strength of about 5 per cent.

To make a gruel of this strength about one and a half ounces of oatmeal is added to a quart and a half of water after previously washed in cold water. This is cooked for thirty minutes down to one quart.

If from six to eight ounces of this are given daily, either alone or as a diluent of milk, it will in most cases relieve constipation and stimulate the appetite as will no other cereal gruel. It renders the stool homogeneous and furnishes a needed iron addition to the baby's dietary.

The food value of gruel prepared in this way is about 1.6 calories to the ounce.

J. D. L.

#### PERTUSSIS VACCINE

Huenekens, E. J.: The Prophylactic Use of Pertussis Vaccine Controlled by the Complement Fixation Test. *American Journal Diseases of Children*, Vol. XIV, 1917, p. 283.

Various authorities are quoted to show that there is no general agreement as to the curative and prophylactic properties of this vaccine. Heretofore conclusions have been based on clinical observations only. The

author has approached this subject from another angle and gives the result of laboratory experiments and observations.

If vaccines are of value we would expect specific antibodies to be present in the blood after the administration of vaccines. The agglutination test for antibodies of pertussis has proven far from satisfactory, while the complement fixation reaction has been much more successful. Bordet and Gengou, using their bacillus as antigen, found a positive complement fixation test in all cases of pertussis. The author selected a number of healthy children who had never had whooping cough and vaccinated them with different pertussis vaccines in order to study the effect of such vaccinations on antibody formation as shown by the complement fixation test. Seventeen patients were used in this experiment, with some commercial vaccine being employed, with others a vaccine prepared by the author.

Varying doses of the vaccine were given over varying periods of time. Most of the cases reacted negatively, but a few, to whom very large doses of vaccine were administered, gave a positive reaction.

In fact, where the large doses as recommended by the New York City Health Department were given, 44 per cent of the cases showed antibodies. The freshly prepared vaccines were apparently more effective than the stock vaccines.

From these observations the author concludes that it is possible to immunize children against pertussis if sufficiently large doses of freshly prepared vaccine are employed.

J. D. L.

#### BONE LESIONS OF THE HIP

Taylor, Harry L., and Barrie, George: Juxta-Articular Bone Lesions of the Hip. *Jour. A. M. A.*, Vol. LXIX, p. 1227.

"The beginner in bone surgery is apt to think of the diagnosis of disease of the hip joint as a simple matter, but long experience will convince him of his error. As pointed out by Gibney in 1884, the diseases of the hip joint are many, owing to the different

infections and pathologic processes, and may be located in the joint, in the bone adjacent to it, or in the soft parts. Many affections which were formerly classed as hip disease or tuberculosis of the hip, especially since the wide use of the Roentgen ray in diagnosis, have come to be recognized as distinct conditions. Such conditions, now classed as separate affections, are coxa vara and slipped epiphysis, lesions fairly well known and not difficult to diagnose. More recently osteochondritis of the hip, Perthes' disease or quiet hip disease (Taylor), a perfectly benign affection, has been studied and separated from tuberculosis of the hip. While studying Perthes' disease, characterized by its mild symptoms and course, our attention was called from time to time to lesions in the neck of the femur or in the trochanteric region, benign in character and causing mild symptoms extending over a considerable period. These cases, usually brought to the surgeon on account of persistent lameness and with little pain or stiffness, could not be distinguished clinically from osteochondritis; but the Roentgen ray revealed instead of a flat and irregular epiphysis, a perfectly normal head and epiphysis with a spot of osteolysis (light spot) in the neck or trochanteric region.

"These cases are often due to the process known as hemorrhagic osteomyelitis (Barrie), which never results in pus formation.

"These cases are often diagnosed as hip tuberculosis, and sometimes as sarcoma."

L. W. C.

#### SUPPURATIVE DISEASES OF THE RIBS AND STERNUM

Beach, Emil G.: *Diagnostic Points in Suppurative Diseases of the Ribs and Sternum*. The American Journal of Roentgenology, Vol. LV (new series), 1917, p. 491.

"It is not uncommon to meet with cases of suppurative diseases of the rib which have been repeatedly operated without any beneficial result, although the operations have been performed by competent surgeons.

"The most frequent cause of failure was found to be the fact that during the opera-

tion one or more diseased ribs were overlooked. This was not always the fault of the surgeon, because on exposure the rib very often appears perfectly normal on its surface, the disease being confined to the cancellous channel of the rib or its under surface.

"The procedure that I employ is as follows: Nearly every one of the cases had one or more sinuses discharging pus, and some as many as ten. These sinuses were injected first with bismuth paste and stereoscopic roentgenograms taken. These clearly outlined and traced the sinuses into the diseased bone cavities. In some instances they led to three or four ribs and the sternum; at other times all the sinuses joined and penetrated only one rib, thus indicating the origin of the disease. At times the injection was sufficient to cure the disease, three out of fifteen not requiring any surgical interference whatever after the injections, but the remainder required very extensive operations consisting in the elimination of every vestige of the disease, no matter where it extended.

"Single plates, probing or exploratory surgery are all insufficient to give definite results.

"The radical cure of the disease of the ribs depends upon a correct diagnosis; and the stereoscopic roentgenogram, after the injection of the sinuses, is the most important."

L. W. C.

#### NEW AND NONOFFICIAL REMEDIES.

LIOIODINE-CIBA. — The ethyl ester of iodobrassicic acid containing 41 per cent of iodine. Lioiodine-Ciba is odorless, tasteless, insoluble in water but very soluble in fatty oils. When administered, it is absorbed almost completely and excreted more slowly than inorganic iodids but more rapidly than with other iodized fats. It is said to be less likely to produce gastric irritation than ordinary iodids. It is supplied only in the form of Tablets Lioiodine-Ciba, 0.3 gm. A. Klipstein and Company, New York. (*Jour. A. M. A.*, June 30, 1917, p. 1985.)



## Publisher's Notes

### THE RESTORATION TO FAVOR OF CREOSOTE.

Creosote has been employed by physicians with varying success for many years in the treatment of bronchitis, especially the bronchitis of pulmonary tuberculosis.

Unfortunately, because of its disagreeable odor and taste, because it caused gastric irritation and distress, nausea and even vomiting, most clinicians were forced to abandon its use. For these reasons creosote is now rarely prescribed. It has fallen into disuse, even though it is admitted that it is possessed of therapeutic value.

#### A NEW CREOSOTE PRODUCT.

Calcreose (a chemical combination of calcium and creosote, containing 50 per cent creosote) very largely overcomes the objections to creosote.

Like creosote, Calcreose will allay cough, lessen expectoration and lower the temperature.

Like creosote, Calcreose improves digestion and nutrition through intestinal antiseptics and stimulation.

Like creosote, Calcreose is a stimulating expectorant.

Calcreose is not a germicide, but it checks bacterial activity, checks putrefaction, lessens the production of toxins—hence reduces the toxemia always associated with intestinal infections.

Like creosote, Calcreose is possessed of all these good qualities but, unlike creosote, Calcreose is practically devoid of all objectionable features.

In other words, Calcreose is an agreeable form of creosote medication, and when given in small doses at first, gradually raised to tolerance, it is free from any untoward effects.

As high as 120 grains of Calcreose has been given daily without digestive disturbance.

#### COMPARATIVELY INEXPENSIVE.

Unlike many creosote compounds, Cal-

creose is comparatively inexpensive. A thousand 4-grain tablets costs the physician or druggist only \$3.00.

Calcreose is made by The Maltbie Chemical Company, Newark, N. J., and is advertised elsewhere in this issue of THE JOURNAL.

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### CHLORETONE AS A HYPNOTIC AND SEDATIVE.

Administered internally, Chloretone passes unchanged into the circulation and is deposited in considerable quantities in the cerebral tissue, the patient falling into a profound sleep. Its action is like that of natural fatigue. Hypnosis passes off gradually, and no habit is formed. Acting upon the central nervous system, therapeutic doses have little or no effect upon the heart and respiratory centers.

Chloretone possesses a wide range of therapeutic applicability. It is a valuable sedative in alcoholism, cholera and colic. It is useful in epilepsy, chorea, pertussis, tetanus and other spasmodic affections. It allays, in most cases, the vomiting of pregnancy, gastric ulcer and seasickness. As a sedative and hypnotic it is indicated in acute mania, puerperal mania, periodic mania, senile dementia, agitated melancholia, motor excitement of general paresis, insomnia of pain (as in tabes dorsalis, cancer and trigeminal neuralgia), insomnia of mental strain, insomnia of nervous diseases, etc. In insomnia it is often effective when other drugs have failed.

The therapeutic dose for an adult is ten to fifteen grains. Good results, however, have been had with doses as small as seven and one-half grains. Sleep usually follows in half an hour to one hour. The administration of Chloretone is not attended with digestive disturbances.

During Infancy and Childhood it is important but difficult to keep the bowels in order. It can be done by the continued use of

## **Liquid Petrolatum Squibb** **Heavy (Californian)**

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# THE JOURNAL

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## Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV  
No. 6

St. Augustine and Jacksonville, Fla., December, 1917

Yearly Subscription, \$1.50  
Single Copy, 15c.

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, December, 1917

Number 6

## ORIGINAL ARTICLES

### WAR WORK OF AMERICAN MEDICAL WOMEN.\*

By ELIZA M. MOSHER, M. D.

The second annual meeting of the Medical Women's National Association, Dr. Bertha Van Hoosen, of Chicago, president, was held in New York City, June, 1917. In view of the pressing need of physicians and surgeons in the war zone and in the devastated districts of Europe, a War Service Committee was appointed by the association to deal with the situation. This body created an executive committee with defined powers, of which Dr. Rosalie Slaughter Morton was unanimously elected chairman. Dr. Morton's selection for this post was a wise one. The Serbian Government had bestowed upon her a decoration for her service in that country. In France special privileges had been given her to inspect and study the French hospitals, and after returning home from foreign duty she has still kept in close touch with the work.

Mr. Leo Schlesinger, of New York City, placed at the disposal of the committee a suite of rooms in his office building, 637 Madison Avenue, admirably suited to its purpose, and there early in June the committee was installed and intensive work began. Before the committee had completed its organization, Dr. Franklin Martin, chairman of the General Medical Board of Washington, asked for an outline of its plan of work. This outline, which Dr. Morton presented in person, received the unanimous approval of the board, and Dr. Morton was appointed a member of it and chairman of a committee of nine women physicians from

different parts of the country, who were selected from a list of twelve submitted to Dr. Martin.

This Committee of Women Physicians of the General Medical Board may be regarded in the light of a congressional committee, its constituency being the women physicians of the United States. If the latter wish to have force and efficiency, organization is necessary. This committee of nine members is not permitted to increase the membership of the General Medical Board; obviously, therefore, it could not encompass the extensive work now going forward under the American Women's Hospitals, which, it is hoped, the general cooperation of women throughout the country will make even more extensive and thorough, and consequently of more value to the General Board. We are now in a position to supply the data necessary to supplement that on the cards sent out from Washington, and on file there.

Copies of the outline prepared for the General Medical Board were laid before Col. J. R. Kean, Director of the Department of Military Relief of the American Red Cross, and the Surgeon General of the Army, General Gorgas. They both expressed the greatest interest in and approval of the work. General Gorgas said that if the war continued for any length of time, the services of every woman doctor in the country would doubtless eventually be needed.

To anticipate this need, the plan of work, with registration blanks, was mailed to 5,000 medical women, asking them to enroll. On October 6th, at the time the first quarterly report of the American Women's Hospitals was issued, 115 women had registered as follows:

- (1) Women's units, 150; (2) Women's

\*A resume of the first quarterly report of the chairman of the Women's Hospitals Committee to the Medical Women's National Association.



units to Allies' armies, 110; (3) Service in established units, 103; (4) Maternity units to devastated regions, 84; (5) Village practice, 25; (6) For service in any of the above five, without choice, 110. The registration blanks are still coming in and it is hoped that every woman physician in the country will record herself as being willing to serve her country in its hour of need.

Dr. Esther Lovejoy, of Portland, Oregon, and Dr. Alice Barlow, of Winnetka, Ill., are now making a study of civilian conditions for our War Service Committee and the following doctors, members of the American Women's Hospitals, have been sent by the Red Cross to the other side:

Esther L. Blair, M. D., Pittsburg, Pa., Women's Medical College of Pennsylvania.

Dorothy Child, M. D., John Hopkins University.

Florence Child, M. D., John Hopkins University.

Edith Lyon Heard, M. D., Women's Medical College, Pa.

Mary Nevin, M. D.

Esther E. Parker, M. D., Cornell University.

Helen L. H. Woodroffe, M. D., Denver Homeopathic, 1900.

Marion C. Stevens, D.D.S., Tufts College.

Ida R. Shields, M. D., University of London, England.

Laura C. Wiggin, Anæsthetist.

In September the Red Cross asked for two units of women doctors to go immediately to Roumania. Their departure has been delayed for diplomatic reasons, incident to the situation in Russia. There are also in readiness forty doctors, who may be called within the next thirty days, and units have been arranged which can be mobilized within a few hours.

The women doctors presented an attractive appearance in their uniforms, which were planned by Dr. Morton at the request of the Red Cross. The lines of the Red Cross uniform for men are followed, and the uniform is both smart and attractive.

The American Women's Hospitals' flag and proper insignia, designed by Miss Brenda Putnam, a niece of that brilliant pioneer among women physicians, the late Mary Putnam Jacobi, has been adopted. The flag is blue and white; the drooping wings, the symbols of the American Women's Hospitals, are grouped around a shield bearing the name "American Women's Hospitals." The pins of bronze are sheltering wings, denoting protection and comfort, with the emblem of the various branches of the service placed upon them.

Open meetings of the American Women's Hospitals were held every Thursday afternoon throughout the past summer and will be continued indefinitely. These meetings, presided over by Dr. Morton, or in her absence by Dr. Emily Dunning Barringer, the vice-chairman, have been of great interest not only to the members of the organization but to the general public. Inspiring speeches by friends of the organization, and officers, doctors and nurses returned from the front have been a feature of these meetings. One of the most interesting of these was the address made by M. Liebert, the French Consul General at New York.

An important branch of the American Women's Hospitals is that of the A. V. A. (American Volunteer Aid). This body was formed after the British V. A. D. (Volunteer Aid Department) and is in a thriving condition. Those wishing to join are given forms on which must be entered all data concerning non-medical women who wish to be laboratory assistants, ambulance drivers, stretcher-bearers, interpreters, dieticians, clerks, etc. A number will be needed in the units already in readiness. These lay assistants have a distinctive uniform for both identification and protection.

The Surgeon General of the Army has expressed his willingness to place in base hospitals, as contract-surgeons, women physicians as anæsthetists, radiographers, and laboratory workers at a salary to be arranged by contract, and not to exceed

\$1,800 per year. The need for laboratory workers is so great that the American Women's Hospitals have opened courses in this branch at the Women's Medical College of Pennsylvania: Women's Hospital, New York, and at the Research Laboratories of the New York City Board of Health. In them courses will be given to college women who have already studied chemistry and biology, in order to fit them, at a nominal expense, to become laboratory technicians and to assist our physicians.

Any physician connected with laboratories which offer such courses in the different parts of the United States, and women wishing to apply for this training, are requested to take up the matter immediately with the National Chairman of Laboratory work, Dr. Martha Wollstein, No. 1 West 81st Street, New York City.

The chairman of the Committee on Army Hospitals in the Home Zone, both for acute and convalescent cases, is Dr. Mary Almira Smith, 33 Newbury Street, Boston, Mass. The American Women's Hospitals have in Boston two hospitals in readiness for convalescent cases and several others near New York. Its Women's Army General Hospital of New York, which has recorded its personnel and equipment in the War Department at Washington, has been told by Surgeon-General Gorgas that it will be notified when this is needed, and that it has the same status as all other army hospitals in the home zone.

The Women's Committees of the General Medical Board had two meetings, July 29th and September 29th. A registration card was sent to the women physicians of the United States with a view to ascertaining how many would be willing to serve in base hospitals as contract-surgeons, radiographers, laboratory workers and dressers of wounds. These cards are now being filed in Washington for reference in case need arises to place women in base hospitals to release men for field hospital service.

The following are the regulations regarding contract practice:

1. Contract-surgeons do not receive pensions except by special act of Congress.

2. The government pays for transportation, quarters, heat and light, the same as furnished the first lieutenants.

3. There is no additional pay for foreign service; the contract specifies where the service is to be and the amount to be received for this special service.

4. Eighteen hundred dollars a year is the maximum, the minimum being whatever agreed to for the particular service to be rendered.

5. The amount is regulated by agreement; the surgeon states his price and the Government accepts or rejects; or vice versa.

6. The immediate superiors are commissioned officers of whatever rank in command at the station where the contract-surgeon serves, even although they be only first lieutenants.

The Surgeon-General's office expressed an interest in knowing how many women wished to become members of the Army Reserve Corps, and a letter was sent by the General Medical Board Committee of Women Physicians to the presidents of medical women's organizations asking an expression of preference for this service, but comparatively few made their offer of war service absolutely contingent upon their becoming *officers* in the Army Reserve Corps.

It is the intention of the Medical Women's National Association to continue the work of this War Service Committee until the end of the war if the need for it continues to exist.

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#### PROGRESSIVE ETHICS.\*

J. H. COFFEE, M. D.,  
Ft. Meade, Fla.

By ethics is meant a code of laws governing the moral actions of men of any given profession and their demeanor towards each

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\* Read before Tri-County Medical Society in Ft. Myers, Fla., April 10, 1917.

other. It does more than that — it defines that which is right and that which is wrong, often bringing out fine shades of differences between acts that are right and those that are wrong. These distinctions are frequently so fine as to be hard to comprehend by those not bound by them. They are all penal laws, in that they carry a penalty. There is but one penalty and that applies to any one or all of these laws. This penalty is banishment from the organization in question. The power to enforce these laws is vested in the organization. The intent is to cast out the offender and hold him up before the world as one who refuses to comply with the customs which are vital to the purity of the morals of the organization from which he has been expelled. These laws were not made for expediency nor were they enacted for any purpose other than as a rule and guide to an honest endeavor towards an ideal. The power which passes final judgment upon this action and makes this punishment real or “tempers the wind to the shorn lamb” is public opinion. This power can be depended upon to adjust itself with the right if given time and proper information.

Medical ethics have existed since the beginning of the medical profession and even at this late date we are without sympathy from public opinion — that court of final appeal. Our ethics furnish fun for the populace. With the aid of charlatans and fakers this tribunal has been made to see the ethics of our profession as an intangible, flimsy, and polite set of rules of order, if not an out and out conspiracy to defraud the people and filch from them their worldly goods. Our reply consists of holding society meetings and exhibiting a healthy grouch. The very idea of publicity is repulsive to us and we imagine that it is a violation of our ethics. Such publicity as would be necessary to acquaint the public mind with the true meaning of medical ethics would be the exercising of good sense and nothing that is real good sense could violate good ethics. We explain to a few intimate friends and

even in this hesitate and flounder guiltily. We impress even our close friends that we only half believe what we say when we try to show that our very existence depends upon altruistic ideas. Frequently we are at a loss for adequate words when trying to show that it would be wrong to advertise our ability to do certain things and why it would be morally wrong to guarantee results. This man guarantees to make a suit of clothes that will fit me and that man guarantees to furnish me with a tire for my car that will last for a stated number of miles and each of these men make good their promise or forfeit their compensation. Now should not the physician guarantee to cure my child of entero-colitis or forever soothe my rheumatic pains and forfeit his compensation upon failure? Even the most ethical attorney will under certain circumstances accept a contingent fee.

Now, gentlemen, I do not wish to take the affirmative of this question against your vociferous negative, because I am fully convinced in the beginning that your cause would be armed with truth, justice and logic clothed in rhetoric and oratory. I say that you know that you are right and so do I, but how about your patients? Do they know it? If we could in some way carry our case to the people and pitch our fight on common sense plains, we could win a victory far grander in its results than has ever been won in the fight for the elevation of medical standards. Then would we see the end of the voracious vulture who so cunningly cultivates a false frightfulness around certain pathological conditions and who wears such elegant clothes and furnishes such well-appointed offices with money stolen from the ignorant while he drives home vile slanders directly and by innuendo against the honest and sacrificing men in the medical profession who live the altruistic life of the true physician. If we could get our case presented before the bar of public opinion in anything like as good sequence as is used by the crooks, we could win, hands down. If we



could only enter into this fight — right as we know we are — we would see the end of that faker who cures Bright's disease and removes parasites from the intestinal tract by rubbing the backbone. Then again it would be entirely possible to strike a hard blow to those heartless sharks who build up false hopes for the dirty dollars they can make by advertising a cure for an incurable disease.

You may not agree with what I have said and you may be right. I think that the Vice-President of the United States said a wise thing when he recently uttered the following words: "I am never so likely to be entirely wrong as when I know that I am entirely right."

Granting that you agree with my premise, I want to present two important steps which seem to me to be necessary in order to bring about better conditions. It is not so hard to find a wrong as to find a remedy for the wrong. It is easy to show that a thing is wrong but it is entirely a different matter to show a better thing in its place.

First, let us be honest enough and brave enough to purge the regular organized medical profession of its liars. There is no more contemptible human jellyfish than the physician who will agree with the prejudices and superstitions of his patients in order to curry favor and because he is too lazy to dispute or argue a question about which he knows that his patient is entirely wrong. He is perfectly willing that his patient believe that it is a case of Bright's disease while he knows that it is merely a cystitis. He is willing to treat and apparently cure a case of Bright's disease while in fact he knows that he is treating a case of catarrhal cystitis. The same principle could actuate that physician to agree that malaria is acquired by drinking impure water, and can be cured by taking calomel. There is also that abominable liar who always arrives just in time to save a life or who has just saved a life by a hair. If they had waited much longer to call him it would have "run into typhoid fever." "Good Lord deliver us." Let us be honest with the

liars in our ranks and reform them or run them out. Let it be known that we will no longer by our silence shield him in his deceptions. When we catch him red-handed, as we often do, let us advise him that we will no longer uphold his quackery, and if this will not bring results, make it an offense against our society and remove him from our ranks. I have heard those whom I know to be good men say that it is necessary to practice some deception, but I am sure they had in mind conditions out of the ordinary and surrounded by circumstances which would make it possible for them to prove that they had acted wisely and perhaps relieved suffering while doing no possible harm whatever. Let us by all means unburden ourselves of the liar and blatherskite.

My second remedy is sure to succeed if tried. Education is the greatest institution of life. From education must come the beauties and pleasures of the world. It is the only thing that can make the world better. The greatest good can be accomplished by educating people when they are young. Now do you get me? Each school should have among its teachers a physician who should be required to teach — not medicine or drugs except incidentally, but health — how to acquire it and how to maintain it. His efforts should be spent in instilling certain fundamental facts into the minds of young women and young men which would make it impossible later in life for a charlatan to impress them except with disgust. Let his instructions have to do with how we are made and why, the location of the vital organs of the body, their functions and the conditions under which these functions can best be carried out and then, above all, the care of these organs and the things that injure them and why. With the youth of the land growing up with a reasonable amount of such information, is it not easy to understand that physicians would have better support in accomplishing the true mission of our calling? The standard of medical education is rising rapidly and it requires more

education to enter a medical school today than ever before and it will require more tomorrow. Physicians are better trained when they begin their practice and are able to do more good than ever before, but public opinion knows it not. They do not understand us because we do not let them. We do not take them into our confidence. We stand aside and allow the unworthy to teach them through the daily press of the country and expect them to give us the support without our giving them a reason for it. We know the reason, but do our patients?

I have never had an ambition to be a reformer. It is a thankless job and besides it calls for lots of work, but it is a shame that we do not use our best efforts to show our people that our ethics stand for their health and happiness. In order that the suggestion herein contained be acted upon, we must make of ours a progressive ethics.

#### THE PREVENTION OF INTESTINAL DISEASES, INCLUDING TYPHOID FEVER.\*

M. L. CRUM, M. D.,  
Bowling Green, Fla.

When I read the letter of our secretary requesting that I prepare a paper on this subject my first thought was, "How easy that will be." But when I considered further I realized that the importance and immensity of the prevention of intestinal diseases would require the best efforts of a master hand for its exhaustive discussion, while I could only offer the efforts of a novice.

I will presume that I am expected to mention only the infectious diseases of the intestinal tract.

So varied and prevalent are the bacteria found in the intestines that we might, perhaps, think of this as a normally infected area. This, however, is not true, for at birth the intestinal contents are sterile. Many forms of intestinal organisms are not path-

ogenic, but it is yet to be proven that they exert any influence beneficial to the host. It appears, rather, that their presence is explained by the facilities for entrance — with food through the mouth, and from the upper air passages, their immense numbers being explained by the fact that the intestinal contents are a splendid media for their nourishment and growth. The absolute impossibility of rendering sterile the alimentary tract is proven beyond question. As previously stated, when the baby is born the intestinal contents are sterile; but even when nothing is taken into the stomach but the mother's milk within a few hours varied kinds of bacteria may be demonstrated in great numbers. This fact is noted to explain with what facility infecting organisms may find lodgment in the tract.

I am not to discuss intestinal diseases, but their prevention. The trend of research in modern medicine is not to cure the sick, but to prevent sickness, and the salutary results we are now obtaining are but the introduction to the successes the future will give us.

That we may defend ourselves against an enemy we must know him. We must be acquainted with his habits, his powers, where and when he may be expected. Without attempting a tedious classification — which is unnecessary for our purpose, as they may be considered as a general class—I want to emphasize the fact that there are two essential factors to the development and activity of all bacterial life—heat and moisture. The absence of these does not necessarily mean that bacteria will be destroyed, for it is well known that they will remain dormant for long periods in a dessicated or even frozen condition, to become active again when the physical conditions surrounding them are favorably changed. If we keep this in mind it will clarify our conception of the problem under consideration.

It is obvious that practically all the infections of the intestinal tract are acquired through the mouth, usually with food or drink. It is proper, therefore, that the food

\* Read before Tri-County Medical Society at Wauchula, Fla., October 9, 1917.

we take should be not considered alone as a matter-of-fact necessity, but also as the possible source of disease.

I find it difficult to epitomize my subject, so in order to supplant tediousness by brevity we will discuss some of the more common sources of infection, with methods for their prevention.

*Water* as used for domestic purposes from the usual sources of supply is never sterile. While in many samples the micro-organisms found are innocuous, their presence proves that the dangerous types might be present with equal opportunity. The facility with which bacteria may be carried for great distances, and kept for a long time in water, makes it very essential that this universal necessity to life be closely guarded and its purity assured. In cities where water is obtained from deep wells, and distributed through a proper waterworks system, there is comparatively little danger of pollution. Practically the only danger point is the storage reservoir, and only criminal negligence could make contamination possible here. But in the small towns and rural districts the question of a supply of pure water assumes more formidable proportions. Where water is obtained from wells driven to a depth of forty feet or more, and, especially, if one or more strata of rock has been traversed, I do not think contamination should be feared. The greatest source of danger from polluted water is in that obtained from open wells. Fortunately, but a small proportion of the people use such wells. The cheapness and convenience of the driven well and pump makes this the popular source of water for most people who are not supplied by municipal water works. The quality of water from brooks, rivers or lakes can never be assured. It may be pure today and polluted tomorrow. Since water is universally used, and may be the vehicle for carrying infective organisms, it follows that proper safe-guarding the water supply against contamination will materially lessen the prevalence of intestinal infections. Do

not forget that water which is pure may be rendered impure by being put in containers which have been improperly cleansed.

*Milk* and *water* are frequently mixed in real life, and may be, with advantage, to a certain extent in this discussion. It should be remembered that milk is a good media for the growth of many forms of bacteria, and especial care should be exercised to prevent its contamination. The two infections most to be feared from milk *per se* are tuberculosis, and pyogenic bacteria from a suppurating process in the glands of the cow.

*Fruits* and *Vegetables*. Here, I believe, we find one of the greatest sources of mischief, especially in green vegetables served in the raw state; as lettuce, celery, young onions, cabbage, cucumbers, etc. It is useless, if it were advisable, to suggest that the customs of a thousand years be abrogated, and have people eat no more uncooked vegetables. Such advice would not be heeded. Therefore, we must minimize the danger which all must admit is present. I said, in discussing the subject of water, that infecting material might be carried long distances by the medium of water. Plants immersed in impure water may retain some of its impurities when the water recedes. Hence gardens should be so situated and drained that it would be impossible for surface water from heavy rains to overflow the plants. Perhaps all remember the disastrous experience of a nearby city a few years ago from this cause. An epidemic of typhoid fever and amœbic dysentery resulted, and the infection was traced to cases of these diseases quite a distance from the gardens. Improper disposition of the excreta from these patients permitted the infecting agents to be washed away by a heavy rain which inundated the gardens.

Fruits have a great attraction for flies — the patron saints of many germs. Grapes, peaches, apples — all fruits which may be eaten without paring offer a common means of carrying infection to the intestinal tract. Such fruits should be protected from the



visitations of flies and washed free of dust before being eaten.

Time forbids that these matters be treated exhaustively. If we can teach the people the real danger, and the means of prevention without creating panic we will have set in motion a force which will diminish intestinal morbidity in a marked degree. Let us never forget our arch enemy—the musca domestica—or common, hairy-legged housefly. Born in, reared and sustained on filth he leaves his disreputable surrounding to dishonor baby's pink lips with a kiss; to use the bread on our dining table for a foot mat, the cream bowl for a swimming pool, and the nipple on baby's bottle for a toboggan. Dirty, disreputable, impudent scoundrel, forcing his attentions where they are least wanted. Swat him in season and out of season—swat him hard; and, when you have done this to his extermination, many of the intestinal diseases which are now tragic in their frequency and formidability will become pathological curiosities. Never permit a breeding place for flies to remain when it can be eliminated.

*Constipation* may be a predisposing factor in intestinal infection. As previously stated the intestinal contents furnish the requisite elements—heat, moisture and pabulum—for the development of bacteria. If there be stasis of the fecal mass it follows that there will be multiplication of the bacteria present. How often do we see an attack of bacillary dysentery preceded by a period of relative or absolute constipation. Functional activity of the intestines obviously militate against infection.

While I do not think it was intended that the intestinal parasites be brought into this discussion, I will digress to mention that disease which confronts us every day—Uncinariasis. The ravages of the hookworm are so appalling that it seems as if it would only be necessary for the medical advisor to state the fact and suggest a remedy to gain immediate attention. But such is not always the case. The cure of uncinariasis is not

always easy, the prevention is. Wear shoes—sound shoes. If a child can be supplied with only pants or shoes, I am not sure but it would be better to buy the shoes and let him hunt a fig leaf. Hookworm disease is not so prevalent nor pronounced in our section as it was a few years ago. This improvement has been made by energetic treatment, and not by prophylaxis. It seems impossible to impress the gravity of the situation upon the laity. This disease can be prevented, absolutely, by protecting the body against infection.

It was my intention to make the consideration of typhoid fever the major part of my paper, but I have trespassed upon your time to such an extent that I will permit what has already been said to apply to this condition in a general way.

Every case of typhoid fever should be cared for by a competent nurse, not only for the welfare of the patient, but for the protection of the community. It is too often the case that the family can not be made to understand that the improper disposal of the dejecta from a typhoid patient subjects every person in the community to a possible infection. It is the part of wisdom to presume that pathogenic micro-organisms are ever present. This will teach us to keep constantly in mind the proper means of avoiding them, for a relaxation of our vigilance might prove serious. In the present imperfect state of our knowledge of bacterial life it is impossible to exterminate the infecting agents, but the proper disposal of the dejecta from every typhoid patient would greatly lessen the chances of a spread of the disease. The infection must gain entrance through the mouth with food or drink. If there be exceptions to this their rarity makes them negligible. Therefore all that has been suggested relative to the care which should be exercised to protect articles intended for food finds justification when we consider typhoid fever.

Typhoid infection is widely disseminated by the so-called typhoid carrier. By a typhoid carrier we mean a person who has had

typhoid fever, and in whose body typhoid germs continue to multiply and are cast off with the excreta for an indefinite period. How long a person usually harbors typhoid germs after recovery from the fever is a disputed question; but we, as physicians, are remiss in our duty when we remove all restrictions just as soon as the patient is able to resume his normal habits. It would be much saner and safer to demand that care be exercised in the disposal of the excreta for a considerable period. It has recently been claimed by several observers that an individual may be a carrier of germs without having had the disease produced by them. I can understand how this might be true, but I doubt if it occurs with sufficient frequency to give it a place in the discussion of the prevention of infectious diseases.

The value of typhoid vaccine as a preventive against this infection is too well known to demand more than a passing notice. My experience has been that it is 100 per cent efficient, as I have seen no one who has received vaccination develop typhoid fever. During the spring months of this year I had a splendid opportunity to demonstrate its value. In one rural neighborhood I treated about fifteen cases of typhoid. I was never able to find the source of infection, notwithstanding I followed every clue, and had the valued assistance of Dr. Hamblin of the State Board of Health. I urged vaccination from the first, but was unable to induce many to take it. After two deaths in one week, one from hemorrhage, the other from perforation, almost every person in the neighborhood submitted to vaccination, since which time I have seen but two cases, father and son, relatives of one of the patients referred to. They had frequently visited the patient, but had not been vaccinated. In all nearly three hundred vaccinations were made. I know of no other means which could have so successfully checked this epidemic. In a few instances the reaction was quite severe. A few years hence a case of typhoid fever will be considered as some-

one's mistake, ignorant, if indeed not criminal.

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#### RELATION OF THE EYE, EAR, NOSE AND THROAT TO THE CONSERVATION OF THE HEALTH OF SCHOOL CHILDREN.\*

SAMUEL F. SMITH, M. D.,  
Lakeland, Fla.

It is of course unnecessary for me to say anything here regarding the importance of the normal functions of the eye, ear, nose and throat to the child in or out of school, as I am sure we all fully realize the necessity of maintaining these organs of special sense in as nearly perfect condition as possible, for the child to attain the best results as to health, education and character, which, of course, are all requisite for their best attainments; as well as their happiness during their entire earthly pilgrimage. Prevention, certainly, has as much of a function here as with any other portion of our bodies. I am convinced that the time is near at hand when the physician will utilize his years of learning, of training, of research and experience, to keep you well, and not just to be around handy when you realize that you are sick nigh unto death, to be sent for posthaste, when probably it is too late to utilize the great knowledge he has given the best years of his life to attain. This plan, which is the very best possible next to prevention of disease, is compared, in my imagination, to a dangerous bridge that all people must cross at various times in their lives, and in doing so, many fall into the raging current below, and while a considerable number are saved, many others lose their lives. Instead of spending our time and money having the bridge properly repaired, we consume probably more time, and money, in preparing more or less successful means of recovering the unfortunate victims after they have fallen into the stream.

The first step is careful and thorough ex-

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\* Read before the Tri-County Medical Society at Ft. Myers, Fla., April 10, 1917.

amination of the child by a physician thoroughly prepared to recognize the normal, and any deviation therefrom of the special organ or portion of their body under his special care. Medical inspection of schools has already done much to place this important matter upon the proper basis. In our larger cities where this is carried out more rigidly than in smaller towns and rural districts, you will find thousands of children that were heretofore allowed to drag along through their school years, attaining only a meager portion of that storehouse of knowledge which should have been theirs, and afterwards perhaps eking out a miserable existence, now crowding the great clinics, or the offices of the family physician, and having the abnormal removed or restored to normal when possible, with proper treatment, thereby being placed in condition to enjoy the comfort and the possibilities that a beneficent Heavenly Father intended they should.

Each child should be carefully examined as to the condition of the eyes, both the lids and the eyeball itself being thoroughly gone over, and properly treated for any abnormal condition found to exist if of enough consequence to in any way cause discomfort or to impede the progress of the child.

The vision should be carefully tested and if sufficient error of refraction found to cause undue symptoms or to endanger the future usefulness of the eye, they should be carefully refracted by one having a thorough knowledge of the eyes as well as the science of optics. Let me impress the importance of early treatment, for if properly carried out comparatively few operations will be necessary upon either the eyes, ears, nose or throat. Proper light and proper position of the body are important factors also in the care of the eyes in the school room, as well as at home.

The ears, important as they are in the school life as well as future years of the child, are deserving of better care and treatment than they now obtain in many cases,

either through thoughtlessness, ignorance, or neglect. The most common affliction claiming our attention here is chronic suppurative otitis media, or "discharging ears," so often passed by with indifferent or perhaps no treatment at all, which is all but criminal with our present knowledge of those things. There is perhaps a semblance of excuse in the fact that many of these cases have long intervals of apparent inactivity and to outward appearances have returned to normal. But with each attack of coryza, we have earache followed with a copious, and in many cases, foul smelling purulent discharge. These conditions should in every instance be carefully treated, not only until the discharge has disappeared, but until no doubt remains regarding the complete removal of the infection from the middle ear, where the trouble is located. In this way you will prevent many cases of defective hearing later in life, and remove the serious danger of mastoiditis and cerebral abscess. But I must hasten on, as volumes could be written along these lines, and each line of each page contain much that would be of intense interest to everyone who has a place in their heart for the welfare of a little child, and I know that includes all of us.

Any catarrhal condition of the nose or throat should be eradicated, and any growths such as polypi removed, inasmuch as proper passage of air through the nose is paramount to the health and progress of the child.

Adenoids, if of sufficient size to cause any obstruction to the proper passage of air through the nostrils or any other abnormal symptoms, should be carefully and thoroughly removed.

The last subject I shall touch upon is the tonsil. This is a portion of our anatomy that has come in for considerable discussion pro and con, and indeed it is a question that should be given serious consideration. The tonsil should be approached carefully and thoughtfully, given treatment where needed, and removed when this is really best for the



child taking everything into consideration; but never made the subject of "Ruthless Submarining" as has been done in far too many cases. Removal of the tonsils is absolutely necessary in many cases for the best interest of the child, but should be done only after very thorough examination regarding its condition, and symptoms both local and systemic, and then performed only by one prepared by special attention to this work, as this is most assuredly a major operation, and not as I have heard stated by some "only a simple little operation that any one can do."

And now, in closing, let me impress one very important fact upon your minds. The condition of the special functions which I have discussed, depend to a very large extent upon the general health of the child. For it is a self-evident truth, that neither the eyes, ears, nose or throat can be kept healthy and strong, without a corresponding condition of the general health of the child. Therefore if the child is trained to observe the rules of living that keeps the entire body in a normal condition, they will have far less occasion to seek the office of the specialist for abnormal conditions of the eyes, ears, nose and throat, and we certainly owe it to these little lives that have been placed in our care, to leave nothing undone that will properly conserve and prepare them for the responsibilities which shall be theirs in the years to come.

### HOW MUCH DO WE OWE OUR PATIENTS?\*

L. L. ANDREWS, M. D.,  
Ft. Myers, Fla.

The vista is far distant between today and the hour of Hippocrates, yet many of today might well sit at his feet and learn anew the lesson of fidelity to trust, personal honor and magnanimity. Do the big thing rather than the little thing. When will men learn that withering jealousy bears its own Nemesis? The circle may be great, but it will circle and

strike its owner to the heart. He who helps his brother helps himself most.

No individual enters the secrets and mysteries of a person's life as his physician. The intelligent patient wants help. Nothing is covered. His faith is often almost sublime. The very presence of his physician calms and quiets and puts to rest the troubled mind or the feverish brow.

Today the measure of such a trust demands more than a strong personality or the magic of a suave manner. It demands noble, clean character. It demands positive knowledge and consummate skill and tact in their application.

It is a long and devious road back to alchemy, the dark arts, and the town barber. Yet we know its course is lit with many a glorious light and not a few bright stars ever pointing forward to our day. The deeds of sacrifice and heroism have been great; mighty the strongholds of superstition and ignorance overcome; marvelous the discoveries made, the therapeutics applied and the results achieved.

To us of the present hour we know that the promised land is not yet entered. There are "cities walled to heaven" and defended by giants. As never before it demands hearty cooperation, concerted action, and sustained effort, if we are to succeed.

The field of vision has so extended and deepened that the serious, conscientious applicant for the major of the three noble arts willingly takes ten years of intensive preparation for its practice. Nor is this all, the horizon is widening so rapidly that the post-graduate school has become a necessity as imperative as the original training. He who will not keep step will soon be out of step; and his sustenance will be that of the rear guard, not that of the vanguard.

But what excuse for wisdom or skill shall be offered? If the original training has been deficient, or if the distant post-graduate course seems an impossibility, this said course will come to our very desks.

Our current literature, our surgical and

\* Read before the Tri-County Medical Society at Wauchula, Fla., October 9, 1917.

medical clinics, and our peerless authorities all but place the literal patient before us. The minimum of effort will visualize and make the scene a reality. It may be your next patient will be one you have just seen in this mental clinic. Yes, the devious, ever illusive thread to the one now under your care may suddenly be picked up here.

How barren the counsel hour, how tragic the end result to both physician and patient is that sanctum that knows not a well-equipped, up-to-date library and an owner who seizes every available moment and hour for careful study and case research! Instead of the intensive history-taking recorded, the rigid physical examination made, and the exhaustive laboratory tests applied, too often the record is deficient, the examination slurred, and the laboratory ignored or forgotten.

Is it saying too much to charge that such an one is a dispenser of sorrow and suffering rather than of peace and health, and that he in reality negatives his license to public confidence and practice? Either he should quit or pursue a course to merit confidence both from his patients and his colleagues.

The necessary office equipment for practice today is both extensive and expensive. It ranges from the test tube to the X-ray machine and radium; from all that the lone practitioner can afford, to the correlated resources of a group of men. Our State is graciously helping us out as best she can. But should we consider this a valid excuse for the lack of a good microscope in our offices together with a thorough knowledge and use of it in our work? That suspicious tonsil case may prove to be diphtheria instead of follicular tonsillitis. The twenty-four or forty-eight hour wait for the State report may prove fatal. A slide of the blood of every patient will more than repay the time and trouble consumed, and not infrequently will be the key to the cause of trouble. How pitiable to see the poisonous vermifuge exhibited "because the baby grinds its teeth in sleep," when positive

knowledge is so easily within our reach! That troublesome stomach case may yield on gastric analysis, cancer; and uremic convulsions may suddenly call you, unless you pay the price — eternal urine analysis. The terms "malaria" and "biliousness" have covered a multitude of sins.

But why particularize further? One word, *efficiency*, dominates our thought today and every man must take his measure. He must produce; he must get results worth while; he must give value received, or the composition of his mettle will be proven to be alloy, not gold.

In the glowing auro of the intellectual and technical standards we are prone to forget the imperative significance of moral and spiritual values. But as conservators of our civic state and the integrity of the home, they are far more potent than the former. The true physician must not only be the careful technician but more often the counselor of the heart and the soul. No one else touches life so closely or so intimately. Its first inspiration and its closing expiration are guided and directed by him, and there is no hour between these two eternities when its heart throb is not subject to his positive command.

Hence preventive medicine assumes its rightful place and dignity. It is noble to cure and to restore; but it is far more noble and God-like to prevent and to conserve. In this realm the physician enters his most vital and useful field. Its possibilities and opportunities are limitless. Already it has bridged continents, destroyed plagues, and robbed the dark angel of many of his most deadly weapons and fortresses. It should enter into the writing of nearly every prescription. Yes, many a prescription had better never have been written and in its place a heart-to-heart talk have been given, outlining before the patient the interrelation of cause and effect in his or her past life in producing the present pathological or psychoneuresthenic state. Then, in clear, unmistakable, positive terms direct the anxious searcher for truth

and health into the realm of Nature's simple yet inexorable laws of metabolism and katabolism. The sequel will be an Eden of peace to many a troubled mind, to many a jaded stomach, to many an outraged system; and the seemingly unconquerable diathesis will give way to the blush and bloom of beautiful health. To such the laurel wreath of victory will be crowned, who thus give out of their heart rather than always out of a bottle.

Precept is good, but example is final. It is its own attorney. In the field of health and morals it knows no compromise. The living, pulsating fact commands attention and obedience, while truth from damaged lips sits lightly. The life of the physician must harmonize with the counsel and the demands made, or how shall he say to his brother, "Let me pull out the mote from thine eye"—when behold, a beam is in his own eye. Over the sanctum of such an one there will soon be inscribed: "Weighed and Wanting."

Every phase of contact with life demands that he maintain the highest degree of efficiency. His personal habits are factors that weigh mightily and can not be lightly esteemed. They make for weal or woe. God alone knows how many diagnoses have been fumbled, how many dissections insulted, how many cases "gone dead wrong" because of the bemuddled brain from the "cup that cheers" or the chloral, the cocaine, or the morphine "dip," or the hours of reckless dissipation.

Today enlightened public opinion casts her mantle of severe censure over such an unfortunate. And the scope of his well meaning but beclouded mind is lessening rapidly. In every such case there must be a quick renovation of habit or the law of the survival of the fittest will soon work his elimination.

It was but a few years ago that public discussion and scientific research (often led by the medical world) began the crusade against these destroyers of life, efficiency, home and happiness. Their complete re-

moval seems now but a question of a few more months or years.

But as soul and body destroying, as terrible disorganizers of the social and civic state as these habits are, there is another narcotizing habit that is rapidly becoming almost universal. It respects neither youth nor age, high nor low, class nor clime. Its degenerating, blighting effects, especially on the physically immature, are prevalent everywhere about us. Bright, promising, vivacious youth droop and wither before it as though struck by the poison of asps.

Towards those of mature years it is one of the most potent factors in producing or augmenting pathological states. What more potent or pathetic comment on its devitalizing, degenerating effects could be asked for than the percentage of "unfits" at our national examining stations for the army? Think of it—almost 50 per cent of proud young America unfit for national defense! And the major damning factor of it all, the cigarette. And now that womanhood and motherhood are rapidly yielding to the "little white slaver," what will the end be? What can it be, when the histogenic elements of a new beginning life are both the products of narcotized parents? Certain it is, the Mendelian law will know no alteration. The future looms tragic. For the sins of our parents will be visited to the third and fourth generation. It can not be otherwise. It is the law of the chemistry of our bodies.

What, then, is the measure of our duty? It is the magnitude of the work to be accomplished, the herculean task of stemming the world-wide nicotine enslavement. Her devotees and fiends are all about us. Nay, they may be in our very homes. The truth is only too evident. The medical profession, the people above all others, who know, and so should avoid it and condemn it, are almost universally its slaves. It may be well to say: "Do as I say, and not as I do," but how infinitely better and stronger, "Do as *I do* and as *I say*."

The physician or surgeon with stained



fingers from the cigarette, or discolored teeth from the cigar, or an auromatized atmosphere from the pipe, or with trembling nerves and a palpitating heart from nicotine poisoning, is no fit example for the youth of our land, nor forceful counselor for him who is held in the lethal coils of this relentless habit.

Then what shall be said of such a physician in the presence of the grave pathological state demanding the very acme of the scientifically trained and cultured mind to fathom its significance, an unerring judgment for correlation in its therapeutics, or the touch of a nerve as true as steel and as sensitive as light for its excision? Efficiency is narcotized; it is below par. It ought to be above par. The measure of the responsibility? The measure of the life just ushered into the realm that knows no waking, or still worse, into the invalidism that knows no surcease of sorrow; because the physician failed, where he would not have failed had he been himself; had the keen sense of perception, judgment, and execution not been clouded by the narcotizing weed.

The voice of science is positive, experience corroborates it; nicotine is an inefficiency producer, a disease promoter and a social nuisance. Dispute it, who can? No more deadly or terrible drugs to the human system are known than the nicotine of the cigar and pipe, and the acrolein or furfuraldehyde produced in the combustion of every cigarette.

The crisis of life in the physician's care are too important and too sacred to bear the crown of narcotized inefficiency, or to be burned on the pyre of the cigarette, or to be shrouded and wreathed in tobacco smoke.

### THE ELIMINATIVE TREATMENT OF ECLAMPSIA.\*

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The condition known as eclampsia dates

from the days of Hippocrates; it has been encountered by almost every practicing physician since that date down the scale of time to our present day; it is almost impossible to find a practicing physician who has not seen and recognized the condition.

The name eclampsia was introduced in the year of 1760, but the condition was known under other names long before that date.

There is not a condition or disease in the long list of human ailments that we have learned so much about the cause during the past century and so little about the treatment; it is indeed alarming when we realize that the mortality is the same today as it was one hundred years ago. A condition so widespread, so common, studied and treated by so many physicians and that the mortality is the same as a century ago is alarming, it seems that the medical profession has something to do along this line; we are progressing rapidly along other lines of treatment and it seems we might do so with the treatment of eclampsia.

The writer was stimulated to write this paper by the experience he has had with this condition.

After receiving his medical degree and completing his career as an intern he located on the St. Francis river, on the Arkansas and Missouri state line in what is known as the St. Francis bottom. Malaria is very prevalent in this district, mosquitoes go in swarms, pneumonia plays havoc every winter and spring in this section. The bottom is overflowed from the river almost every year and sometimes several times in one year. From the above description you can readily see that the conditions were very unsanitary. It was here and under these conditions that the writer realized the gravity of eclampsia.

As a hospital intern he had failed to see many cases of eclampsia, and the cases that he had seen were not of the malignant variety as the majority of the cases proved to be in this locality.

Eclampsia was frequently encountered in

\* Read before Tri-County Medical Society in Lakeland, July 10, 1917.

this locality and as the cases usually gave histories of malaria and had enlarged spleens, it led the writer to believe that malaria was a predisposing cause of eclampsia. However, in this locality the physician does not have the pleasure of watching and observing his patients as he should, as the custom is to call a physician at confinement only; he is seldom consulted previous to the eclamptic convulsion or confinement.

Under the above condition the writer is frank to admit that his mortality was almost twice as high as that quoted by the text books. It was here he, so to speak, "got busy"; he did not lose any time in looking through the literature on eclampsia in order to reduce his mortality. In going over the literature he found not one authority was able to give the definite cause of eclampsia; however, all authorities arrived at the conclusion that the cause was faulty elimination, but not one of them advised vigorous elimination, claiming that elimination through the skin by the use of hot packs and pilocarpine was too depressing and that diuretics was contraindicated as the kidneys needed rest rather than stimulation. Also that elimination through the bowels was endangering the patient to septic fever as the birth canal may become infected from the fecal discharge and the infection be carried up into the uterus in case a forced delivery is to be done later as we so often have to do in these cases and, too, that these patients are not in any condition to withstand purging.

After following the treatment outlined by the text books and failing to reduce my mortality I decided to try vigorous elimination through the bowels as theoretically, the condition being caused by faulty elimination, free elimination should be the proper treatment and as I felt I could not increase my mortality and possibly reduce it. I failed to get any results from the use of croton oil or elaterian.

After adopting the eliminative treatment my mortality dropped to zero for the mother

and has remained there to this day; the infant mortality has been reduced also.

I will report the following cases, some occurring before labor and some after, to illustrate in the different cases:

*Case 1.* Mrs. J. H., age twenty-four, her first pregnancy. I was called to her at 5 p. m. She had one convulsion before I arrived and one in my presence. I gave her one H. M. C. number one to control the convulsions, and then administered fifteen grains of calomel and two ounces of castor oil; I then returned home. She had another convulsion five hours later, at which time I returned and found her having pains and cervix dilated; she was given another hypodermic H. M. C. number one and delivered under chloroform anæsthetic of an approximately eight months' dead fetus. She was put on magnesium sulphate one ounce every morning for six days; she made a speedy recovery.

*Case 2.* Mrs. L. C. It was her seventh pregnancy; she had never had eclampsia before; she was seven months pregnant. I was called to her at midnight; she had one convulsion before I arrived and one a few minutes after I arrived. I at once administered one H. M. C. number one hypodermically, also ordered fifteen grains of calomel and two ounces of castor oil to be given at once. She was given one ounce of magnesium sulphate every morning for one week; she had one convulsion the second day after she was put on the treatment, at which time she received another hypodermic of morphine and hyocine; she made a good recovery and I delivered her two months later of a normal labor.

*Case 3.* Mrs. M. B. This was her fourth pregnancy; she had her first convulsion at 7 p. m. She had her second two hours later, at which time I arrived. She appeared to be full term; pains had set in and the cervix was dilated. She was given one H. M. C. number one, ten grains of calomel, and two ounces of castor oil, after which chloroform was administered and she was delivered of twins; she received magnesium sulphate one

ounce daily. She made a speedy recovery and she and the babies are alive and well today.

*Case 4.* Mrs. W. C. It was her second pregnancy. She had never had convulsions; five days after delivery she had a convulsion. I was called and she was given fifteen grains of calomel, two ounces of castor oil and a hypodermic of morphine and hyocine; she continued to have convulsions for thirty-six hours, except when she was narcotized on morphine and hyocine; she received magnesium sulphate one ounce every twelve hours for three days, after which it was given daily for one week. She made an uneventful recovery; mother and child are alive today.

*Case 5.* Mrs. D. H. It was her second pregnancy. She had never before had eclampsia. She was delivered by a midwife at midnight; she had a convulsion twelve hours later, at which time I was called; when I arrived she was having her second convulsion and had a third convulsion thirty minutes after the second one. She was semi-comatose. I ordered one H. M. C. number one to be given hypodermically. I mixed fifteen grains of calomel and castor oil, two ounces, and administered it at once; four hours later she was given two ounces of castor oil, after which magnesium sulphate was given daily for one week; she made a speedy recovery.

From the report of the above cases you can readily see that the treatment followed was to control the convulsion with morphine and hyocine and chloroform if necessary, and to administer calomel and castor oil, after which magnesium sulphate was given freely; the reason for giving the oil first, as most patients are semi-comatose and they do not appear to be so readily strangled on oil as on salts or other thinner liquids. By following the calomel at once with salts or oil I do not think we get as much griping as if we wait longer to give the salts or oil, and I think we can give larger doses without salivation by following the calomel at once in this way.

## VALUE OF NURSE HIRED BY CITY OR DISTRICT, "COMMUNITY NURSES."\*

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Before we can come to any conclusion as to the value of such employment, we must consider the amount of labor to be performed and the results which are to be obtained. As this field of work is so large and the results so diversified, it would be impossible in this short a time to go into the matter in detail, or to quote statistics by which such values are usually supported. Rather let us consider the work in a more general manner under separate divisions:

1st. As to prevention of diseases in general.

2d. As to prevention of contagious diseases.

3d. Assisting those already under medical care.

The most general duty of the district nurse is assisting in preventing disease by her advice in matters of hygiene, sanitation and dietetics.

The dissemination of this advice is usually undertaken by conducting meetings with mothers' clubs, church and social societies, and by talks to school children. Then in more detail to small groups of neighborhood women, and when time will permit, to individuals, if they request such advice. This part of the work will be mostly educational, and in these matters she will often find it well to arrange larger meetings, then invite some doctor to lecture on a special subject which she finds to be needed in a certain locality, or at a certain time.

In prevention of contagious diseases, she is the health officer's most valuable assistant. In many cases, it is she who first sees some child that is ailing and yet not sick enough to cause the family to call a doctor. We all know too well how many of our epidemics start from just such conditions. Here is a

\*Read before Tri-County Medical Society at Wauchula, October 9, 1917.



nurse that they may call without expense and whose advice as to the necessity for a doctor is usually followed.

However, with the coming of the health officer, her duties are not ended. If he should decide that the case is one to be quarantined, and no special nurse is to be employed, then the community nurse must come and demonstrate to the family what methods the health officer wishes to use in this particular case for safeguarding the other members of the family as well as the neighborhood. Then she will make an effort to keep under observation the children of this neighborhood, ready to investigate any case of slight illness that might occur in the vicinity, and report the same to the health officer; thus she saves this officer much time and adds very greatly to his efficiency.

With the patients already under medical care and many there are who can not afford a special nurse, to these she must devote much of her time. While she can not go to the home and remain there, steadily, as does the nurse with only one patient, yet she can go to the home and inquire from the doctor his orders. She can take the person in charge of the sick room, and instruct her in detail how these orders are to be executed. She should make out a proper diet list for the patient, and instruct some one in the preparation of the same. Leaving a chart, she may call once or twice a day just for a moment to record temperature, pulse, respiration and other facts that the doctor would desire upon his next visit.

In case of typhoid and similar diseases, the doctor will wish her to go to the home and actually demonstrate to the family how precautionary measures are to be conducted, and what is expected in the care of infective material.

It is astonishing the number of such visits that can be made during hours that would not interfere with the general work. These are the usual duties expected in this work.

But there is one more condition which may not have been called to your attention

before, one which I did not realize until I had seen many other results from these labors—a factor which I wish to bring to you for most serious consideration.

No public servant, be it religious advisor or doctor, comes so intimately in contact with the moral life of the women and children of a community as does the district nurse. It is her privilege to give advice to members of many families long before conditions are such as would require the advice or services of a doctor. To her they will apply for advice with much greater freedom. This service then may be summed up in its relation to the public as educational, economical and moral. On the economic value practically all community nurses are hired and maintained; from this value alone the results have been such as to warrant its survival. But from the intangible moral and educational value comes the best results of these labors, something not to be measured by dollars. Assets not considered by the officials who vote the money for the system's maintenance.

These are the values which doctors or others who watch the work most carefully, come to respect most highly. Needless to say that wherever this service is introduced it must run the gauntlet of adverse criticism, for no human being could answer so large a number of duties to the satisfaction of all. But when this system is once established and passes the first waves of criticism, it soon meets with a public approval from which there need be no fear that it will ever be abandoned. It will continue to grow until it is established as an essential public service under firm public support.

Then let us consider for a moment the requirements of this public servant. She should first be of the highest moral character, well educated in a recognized hospital training school, which should be supplemented by special instruction in dietetics, sanitation, and practical bacteriology of contagious diseases. In localities where this work has reached its highest development, college

graduates with nurse's training, and in some few instances women physicians have taken up this work as supervisors of large cities or districts. In addition to these she must maintain the highest ethical standards, regardless of her own personal views. She must favor no certain school of medicine nor religion. One creed she must follow. That is a diligent support of our established public servant—the health officer. Thus through scientific training and education she becomes a valuable and efficient godmother of the community in which she labors; seeking ever the source of disease, bearing warning of danger to come, and lending a helping hand to the afflicted.

#### THE SANITARY INSPECTOR IN THE PREVENTION OF DISEASES.\*

H. O. SNOW, M. D.,

Tampa, Fla.

The sanitary officer's duty in regard to the prevention of diseases are of primary importance in the prevention of diseases of the typhoid group. These diseases are contracted through the contamination of water, milk or food. The infection may be fly-borne or may be conveyed by a carrier, in the handling of these articles; the former is the most usual means of conveyance. The open dirt closet is, in Florida, one of the greatest menaces to public health and is the main source of infection from flies. The district officers are trying to impress upon the doctors and the laity the importance of flyproofing them in some manner. The improper disposal of the dejecta from typhoid or other fly-borne diseases is also a fertile field for infection. We often find that physicians are careless in regard to instructing nurses or people who are caring for cases of this kind, how to disinfect and dispose of the dejecta where there is no sewerage disposal, or take too much for granted and think that they should know how to do so, in this manner jeopardizing the health of the community and the sur-

rounding country. We occasionally meet with cases of rank ignorance. For instance, I asked a physician who was treating a case of typhoid fever near a small town in my district, how he disposed of the dejecta. He replied, "I just have them spread it out on the ground in the sun; the sun kills the bacilli." I asked him how about the flies, and he replied, "Oh, it has not been proven that typhoid fever is a fly-borne disease." I however informed him that the State Board of Health considered it so and wanted him to have it disinfected properly and buried. He agreed to make proper disposal of it in the future. This is an exceptional case I am glad to say, and in spite of his promise I shall feel safer to watch his cases from now on and see that he keeps his promise. In another instance I asked a physician the same question and he told me that he had the dejecta disinfected with one of the phenol preparations and then buried it. He very kindly invited me to see the patient with him. I found that the people disinfected the dejecta and poured it in a hole that they had dug in the back yard, about ten inches square, soiling the sides, of course, and leaving it uncovered until the hole was about full, then covering it up with dirt. Now the physician in this case had told these people what to do, but neglected to see that his orders were carried out. I try to get the ideas of the physicians in my district in regard to this matter as they are the ones that we have to depend on, and impress on them the importance of seeing that their instructions are carried out to the letter, and that the dejecta is not exposed to the flies from the time that it is voided until it is covered up. I feel quite sure that a number of cases can be traced to just such carelessness as I have related. We are trying to persuade people in the small town where there is no sewerage disposal to install L. R. S. closets or septic tanks for the disposal of night soil, either of which can be installed at a very small cost. The barrel tank which is made of two ordinary oil barrels connected by a

\*Read before Tri-County Medical Society at Wauchula, Fla., October 9, 1917.

two and one-half-inch pipe for about five dollars, and the concrete tank for about twenty to thirty dollars, will take care of the dejecta of about eight or ten people; this does not include the cost of the buildings. The Stevens or other cans which are fly-proof, if properly fitted, are the next best method of sewerage disposal, but have the objection of requiring constant care to accomplish the desired purpose, while the L. R. S. closet with the addition of a bucket or two of water a week practically takes care of itself. There has been a great many Stevens cans installed in Florida in the past three months and they, with the septic tanks that are being installed, will no doubt help to a great extent to reduce the death rate from fly-borne diseases, which is twice as great in Florida as it is in the registration area of the United States. The present Board of Health has undertaken to reduce this high mortality rate to or below the normal rate. We have undertaken quite a proposition, but with the assistance of the physicians of the state and by appealing to the laity when we get an opportunity, we feel that it can be done.

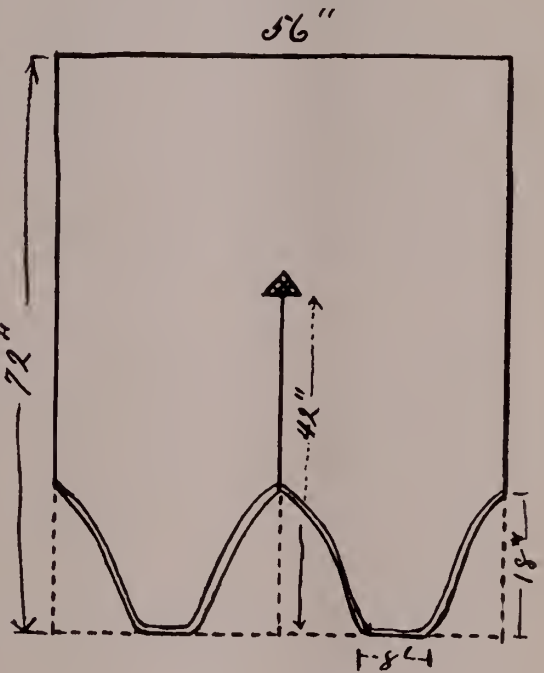
#### A NEW OBSTETRICAL SHEET.

G. H. EDWARDS, M. D.,  
Orlando, Fla.

In my obstetrical practice, when I can have a trained nurse and other intelligent assistants, I manage very satisfactorily from the point of sterility with the ordinary sterile sheet or sterile towels to protect my patient during delivery. But among my patients who cannot afford a trained nurse and among those, principally in the rural districts, where intelligent assistance is often hard to obtain and where the number of assistants are limited, I have much trouble in maintaining a septic field. The patient is more or less restless, my sterile towels or sheet are constantly falling from position and are being replaced by my too-willing assistants, so that in a short time I have no sterile areas of which I am sure.

This has led me to devise the accompany-

ing described sheet, or more literally, obstetrical breeches, which I put upon the patient after having donned my own sterile gown and gloves; which in the first place is not easily displaced, and which can be kept in place by an assistant without any need of approaching the seat of operation. In case of forceps or operative delivery, my assistants can hold the limbs from the outer and under side, their arms covered by the sheet, without any danger of coming in contact with me or my instruments.



I have the sheet folded so that, when removed from the package, I can lay it upon the chest of the patient, and by simple turning downward and inward, fold after fold, the sheet or breeches lay over the patient in the desired position without having to be shifted from side to side. Taking hold of the toe of the breeches, I hold it up and the patient lifting her foot, slips it into the pocket made for same. This is repeated with the other leg.

An assistant can put her hand under the outer edge of the breeches, take hold of the knee, hold it outward and steady it without any danger of coming in contact with me.



If the sheet tends to slip downward or out of position, the same or another assistant simply taking hold of the upper margin, over the breast, pulls it into position, but this is rarely ever necessary unless the patient is extremely restless. In cases with no assistants, I have the whole sterile field in front of me and I, myself, can hold the knees, feeling sure that it has been touched by no one else, as it rarely slips and therefore needs no handling.

The accompanying illustration gives the dimensions of the sheet and explains how the breeches are made. The double lines show where the edges of the sheet should be sewed together making the pockets. The dotted lines show the portion of the sheet which is cut off and thrown away. The shaded area in the middle is the reinforcement to keep the sheet from tearing further up.

#### PROPAGANDA FOR REFORM.

**SOME MISBRANDED NOSTRUMS.**—The following "patent medicines" were found misbranded by the Federal authorities: A. D. S. Cod Liver Oil Comp., claimed by the American Druggists' Syndicate to be a sovereign remedy in pulmonary tuberculosis, was not possessed of the virtues claimed, nor a preparation of the active principles of pure Norwegian cod liver oil. Johnson's Chill and Fever Tonic, claimed to be a "guaranteed remedy" for dengue fever, typhoid fever, measles and la grippe, was a watery solution of Epsom salts and cinchonin hydrochlorid. A. D. S. Peroxide Talcum Antiseptic and Deodorant, sold by the American Druggists' Syndicate with the claim that it contained a peroxide and to be a wonderful antiseptic and germicide, was found to have no antiseptic properties and no detectable peroxide. Dr. King's Royal Germeteur, claimed to be a "germ destroyer," was found to consist essentially of 98 per cent water and 2 per cent sulphuric acid, saturated with hydrogen sulphid. (*Jour. A. M. A.*, Nov. 18, 1916, p. 1541.)

**THE LUTIN TEST.**—Confirmatory of previous investigations, H. N. Cole and H. V. Parysek finds that some non-syphilitics respond positively to the luetin test and that in those non-syphilitics who do not respond spontaneously the reaction can generally be provoked by iodides. They also demonstrated that the reaction may be provoked by potassium nitrate and potassium bromide. Proving that the potassium ion in the potassium iodide and bromide was not concerned in the reaction, they found that the luetin test may be provoked by sodium bromide, sodium iodide and calcium bromide (*Jour. A. M. A.*, April 14, 1917, p. 1089).

**ABOLITION OF THE SALVARSAN PATENT.**—The Chicago Medical Society and the St. Louis Medical Society urge the abolition of the Salvarsan patent. The patent should be abrogated, not only because the patentees have not supplied the demand, not alone because they have dictated to the medical profession who should have the drug and how much a physician might have, not alone because of the war with Germany, not alone because of the special needs of the government at this time for the control of venereal diseases, not alone because, as some claim, the patent at Washington does not correctly describe the product, but also because the people who are supplying this product are charging prices that are exorbitant. In order that a sufficient supply, to control the ravages of one of the most serious diseases that afflict humanity, may be assured, it is the duty of Congress to abrogate the Salvarsan patent (*Jour. A. M. A.*, April 21, 1917, p. 1187 and 1203).

**Q-BAN HAIR COLOR RESTORER.**—Untoward effects from the use of Q-Ban Hair Color Restorer are reported. The Connecticut Agricultural Experiment Station reported the "restorer" to be a perfumed, alcohol-glycerin solution of 1.68 gm. per 100 c.c. of lead acetate, containing 3.08 gm. of free sulphur in suspension. The Connecticut report states: "It is simply one of the many familiar lead acetate-sulphur

preparations, and its use is by no means free from danger." (*Jour. A. M. A.*, Jan. 6, 1917, p. 54.)

**EMETINE IN DYSENTERY AND PYORRHEA.**—Emetine is accepted today as an almost ideal specific against amebic dysentery. Experience indicates that by its use abscess of the liver can be prevented and even cured. When a differential diagnosis between amebic and bacillary dysentery cannot be made, emetine may be of diagnostic value because improvement follows from its use if the case is amebic. In neglected cases and some other forms of the disease the emetine treatment may fail of complete success. As a direct cure for pyorrhea emetine seems to have failed, not because it does not act on the ameba which are found in the pyorrheal pockets but because pyorrhea is not caused by ameba. (*Jour. A. M. A.*, Feb. 3, 1917, p. 374.)

**THE PHENOLSULPHONEPHTHALEIN TEST.**—It has been assumed that excretion of less than 60 to 80 per cent of phenolsulphonephthalein in two hours is an indication of renal insufficiency. It has been found, however, that in certain experimental conditions, phenolsulphonephthalein may be destroyed in the body and therefore not appear in the urine although the kidneys function normally. If this condition is found to occur in clinical cases the interpretation of the tests may have to be limited to this: an excretion of 60 to 80 per cent, i. e., a positive result, within two hours after the injection of the phenolsulphonephthalein is evidence of satisfactory renal activity. (*Jour. A. M. A.*, Feb. 3, 1917, p. 379.)

**FATE OF TRYPSIN IN THE STOMACH.**—Judging by recent experiments, it appears that the proteolytic enzyme of the pancreas isolated as trypsin is capable of withstanding a rather long digestion in presence of hydrochloric acid and pepsin, provided that sufficient protein is present to combine with all or a part of the acid and so bring the free acid down to a certain level. From the observations it seems possible that some

tryptic digestion may occur within the stomach when the free acid is low from combination with protein. The results do not, however, even remotely suggest that the administration of a few grains of the various commercial products claimed to contain trypsin or pancreatin would have the slightest therapeutic significance. (*Jour. A. M. A.*, Feb. 17, 1917, p. 554.)

**FIRWEIN.**—The Council on Pharmacy and Chemistry reports that Firwein (The Tilden Company) is sold under the claim that when swallowed it has a "predilection" both for the bronchial mucosa and also for the genito-urinary organs. The Council finds that little information is given in regard to the composition of Firwein. As the composition of Firwein is secret, the therapeutic claims unwarranted and its use irrational, the Council declared it inadmissible to New and Nonofficial Remedies. (*Jour. A. M. A.*, Feb. 17, 1917, p. 564.)

**FIROLYPTOL PLAIN AND FIROLYPTOL WITH KREOSOTE.**—The Council on Pharmacy and Chemistry reports that Firolyptol (The Tilden Company) is said to be composed of eucalyptol 10 drops, cottonseed oil  $\frac{1}{2}$  ounce and Firwein enough to make 1 ounce, and that, as the composition of Firwein is secret, the composition of Firolyptol is also unknown except to the manufacturers. Firolyptol with Kreosote is said to contain, in addition to whatever may be the component parts of Firolyptol, 10 minims of creosote to each ounce. The advertisements for these two preparations seem to have for their keynote the assertion that cottonseed oil is a particularly valuable nutriment and that when combined with the constituents of Firolyptol and Firolyptol with Kreosote it becomes particularly valuable to the tuberculous. The council discussed the extravagant claims made for these proprietaries; reminds that food and fresh air, not drugs, constitute the fundamentals of the treatment of tuberculosis; and finds that neither of the products is acceptable for New and Nonofficial Remedies. (*Jour. A. M. A.*, Feb. 17, 1917, p. 564.)

## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or P. O. Box 136, Jacksonville, Fla., U. S. A.

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**Next Meeting — Tampa — May, 1918**

## INCREASED RANK AND MORE AUTHORITY FOR MEDICAL OFFICERS.

As most of our readers are aware, an amendment was introduced into Congress at the recent session which, if it had been adopted, would have given the medical officers in the Army the same rank that prevails in the Medical Corps of the Navy. Specifically the amendment provided that there should be twenty-five one-hundredths of 1 per cent of major-generals, the same proportion of brigadier-generals, 4 per cent of colonels, 8 per cent of lieutenant-colonels, 23.5 per cent of majors, 32 per cent of captains, and 32 per cent of lieutenants, *this to apply to both the regular and the reserve corps men*. Thus, if there are 10,000 medical officers in active service, there might be 25 major-generals, 25 brigadier-generals, 400 colonels, 800 lieutenant-colonels, 2,350 majors, 3,200 captains and 3,200 first lieutenants. This amendment lapsed without action by the ending of the session. The substance of the amendment, however, will be incorporated in a bill which will be introduced in both the Senate and the House at the coming session of Congress.

Medical officers must be equal in rank and authority with line officers if they are adequately to carry out the duties for which they will be held responsible. This fact has been emphasized by the experience of our allies in the present war, as well as by our own experience in the past. Our allies admit that in the beginning the medical officer did not have the rank, and consequently the authority, he should have had and that, for this reason, there have been grievous consequences. Among these was the disastrous experience of the British Army in the Mesopotamian campaign as a result of the failure of the medical service. The report of this tragedy, made by a board of nonmedical men, showed that lack of authority of the medical officers was an important factor. The medical officers were practically ignored. They were not advised as to the character



of the expedition that was being undertaken, and as a consequence, they were unprepared for what happened. When later a medical officer made urgent representations in regard to the actual conditions obtaining, which in his opinion needed prompt action, he was threatened with arrest and removal from his post. When the actual results came, the blame was thrown on the medical department, of which this medical officer was a member. The medical officers were censured because they had not protested more vigorously. We had a similar experience in 1898 when our medical officers were criticized for insanitary conditions at Chickamauga and elsewhere, although there was plenty of evidence to show that they had protested against these conditions to line officers. The whole sad story is told in detail in the Dodge report. There, also, will be found testimony that line officers treated with contempt the recommendations and protests made by medical officers. The medical officer is without influence simply because his shoulder straps indicate lower rank than that of the line officer with whom he is associated. Some may sneer, but the fact remains that it is rank that counts in both the Army and the Navy.

Of course rank brings with it increased pay. This, however, is immaterial. At the same time, it should not be forgotten that most of the physicians now in the Medical Reserve Corps have not only left the comforts of their homes, but also have given up practices which in the majority of instances yielded far more income than the pay they would receive as medical officers of the Army even if they had conferred on them the highest rank that the proposed law would provide. Among these medical reserve officers are many of the most prominent men in our profession, including the leading men in the specialties, as well as our best surgeons and internists.

When the war broke out, there were less than 450 medical officers in the regular Army Medical Corps. Today there are com-

missioned, including officers of the Regular Army, the National Guard and the Medical Reserve Corps, at least 17,000 physicians. Less than 1,000 are in the Regular Army Medical Corps. Under the present law these regular Medical Corps officers are entitled to the grades of lieutenant-colonel and colonel; and in the case of the surgeon-general, to that of brigadier-general<sup>1</sup>; the highest rank that can be conferred on any one of the other 16,000—that is, on any reserve medical officer—is that of major.

May we remind our readers that the men in active service will be prevented by the regulations from using their influence in this matter, and that the duty of pushing this measure rests on those who stay at home? Every physician has representing him in Congress one man in the House of Representatives and another in the Senate. If every physician will let his representatives know that this proposed measure should become a law, and if in addition he will enlighten his neighbors in regard to the matter, an effective public opinion will be created. The time is opportune; congressmen are at their homes. Write or speak to your representatives now; get your neighbors to do likewise—not for the good of the medical profession, but for the good of the service.—*Journal American Medical Association.*

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1. Surgeon General Gorgas has the rank of Major General by special act of Congress.

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#### THE EFFECT OF RANK ON THE DUTIES AND RESPONSIBILITIES OF THE MEDICAL OFFICER.

The importance of the medical officer in the armies engaged in war, as indicated by the rank and authority given him, is less highly esteemed in this country than in any other, including both our allies and our enemies. Medicine has accomplished great triumphs in the armies of Europe. Under unprecedentedly difficult conditions, sanitation has been so ably maintained that both morbidity and mortality from the infectious diseases are less today in the military than

in the civilian population of the warring nations. In the British Army, 80 per cent of the wounded have been returned to duty. The number of hospitals in France reaches into the hundreds, and for the most part their equipment is excellent. Scientific laboratories are carrying on practical research investigations. Chemists are finding antidotes for the multitudinous poisonous gases turned on by the Germans, and are discovering new compounds to be used offensively. Within twenty-four hours after the first discharge of chlorin by the Germans, not only had the nature of the gas been determined and an antidote found, but protective masks were being made; and within ten days the Germans were being treated with the more deadly phosgen. Indeed, scientific studies made at the front saved the armies of Great Britain and France from complete annihilation. Rehabilitation hospitals in which the badly injured are supplied with artificial limbs and other devices are working successfully and converting the apparently hopelessly maimed into productive, self-supporting citizens. In fact, these institutions constitute one of the great triumphs of military and conservative medicine. Every wounded and sick soldier can be instantly located and his condition reported to his friends. In this way the discontent arising from anxious waiting for news is avoided. There has been no breakdown in the medical service in the great armies of Europe, as has been the case so often in the past and with us in 1898. When a son is killed in battle, parents seek and find consolation in the proud knowledge that he has died fighting for his home and his country; but when he is wounded or sick and dies from neglect, there is no consolation, and in the most patriotic soul a bitterness against those in authority develops.

All this and much more might be said concerning the efficiency of the medical service of our chief allies. What is the explanation of its efficiency? The answer is that the medical officer is given support backed by rank and authority. A line officer in the

British Army hesitates a long while before he rejects the advice of his medical colleague, because that colleague has rank and authority commensurate in some degree at least with his own, and is recognized as his superior in the special line of work. Compare this with the record of the congressional inquiry into the conduct of the War Department in the war with Spain, when, according to his own testimony, the commanding officer at Chickamauga in 1898 ostentatiously drank from a well condemned by the medical officer, while his hospitals were filled with typhoid fever patients. We have gone into this war with the medical officer invested with no more authority than we had in 1898. Is it unreasonable to ask if we are to repeat the experiences of that time? However, we are told that the line officer of today is much wiser than his predecessor of twenty years ago, and since he makes this statement himself, we must give it credence. We certainly hope that it is true. It is the duty of the medical profession to protest against this condition. The medical men of this country are not slackers, as is shown by the fact that more than one seventh of their total number have voluntarily offered their services to their country, notwithstanding the failure of those in authority to give the reasonable recognition asked. We have asked for increased authority, and in the Army this can be secured only by high rank, because when a medical man goes into the service the government puts its stamp on him just as it does on the coin of the realm; and 30 cents will not buy a dollar's worth of anything. So far the protest has fallen on deaf ears.

Medical men will play the game and do their duty, whatever may be the verdict in this matter; but it should be clearly understood that they are going into the game under a heavy handicap. They will do the best they can; but if discontent should arise from poor or poorly prepared rations, if respiratory diseases prevail as the result of overcrowding, if pneumonia becomes widespread because barracks are not heated and

APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

.....  
....., 191.....  
To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.

Sir :

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....  
.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....  
.....
4. When and where were you naturalized? (For applicants of alien birth only.).....  
.....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....  
.....
10. If either parent or brother or sister has died, state cause and age in each case:.....  
.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....  
.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc.:.....  
.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates: .....  
.....
16. With what ancient or modern languages or branches of science are you acquainted?.....  
.....

\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.



17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result : \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.

soldiers are not warmly clothed and amply provided with blankets — if all these things happen, the medical officer will continue to do the best he can under the conditions, but he will not be responsible for the conditions. —*Journal American Medical Association.*

### OUR HONOR ROLL.

Our Honor Roll as published below now constitutes a grand total of one hundred and forty-four physicians. They are divided in the services as follows: Medical Corps—Lieutenant Colonel, 1; Medical Reserve Corps—Majors, 4; Captains, 25; 1st Lieutenants, 100; total, 130. United States Navy—Passed Assistant Surgeons, 2; Assistant Surgeons, 3; total, 5. National Guard United States (Fla.)—Majors, 3; Captain, 1; 1st Lieutenants, 5; total, 9. The list is gradually becoming complete; we urge all to help us maintain it in a thorough manner.

#### MEDICAL CORPS, U. S. ARMY.

##### *Home Address.*

Lieut.-Colonel Joseph Y. Porter.....Key West

#### MEDICAL OFFICERS' RESERVE CORPS.

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#### THE NAVY.

Passed Assistant Surgeon W. P. Dey.....	Jacksonville
Assistant Surgeon Thomas S. Field.....	Jacksonville
Assistant Surgeon Boyd Gilbert.....	Pensacola
Passed Asst. Surgeon J. Knox Simpson.....	Jacksonville
Assistant Surgeon D. C. Thompson.....	Pensacola

#### NATIONAL GUARD UNITED STATES (FLA.).

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Major Ralph Green .....	Jacksonville
Major James H. Livingston .....	Jacksonville
Captain W. J. Buck .....	Gainesville
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1st Lieut. John R. Hawkins .....	Williston
1st Lieut. Z. V. Johnson .....	Milton
1st Lieut. Lucien B. Mitchell .....	Tampa
1st Lieut. J. M. Mitchell .....	Millville

### COLD-PACK CANNING AND BOTULISM.

The United States Department of Agriculture authorizes the following statement:

Botulism, often called sausage poisoning, is a specific intoxication brought about by *Bacillus botulinus*, an organism isolated by Van Ermengen from insufficiently cooked sausages which had caused a severe outbreak of food poisoning in Belgium in 1895. The symptoms (nausea, gastric pains, visual disturbances, muscular weakness, etc.) are

caused by a definite toxin or poison produced by the *Bacillus botulinus* outside of the body.

The *Bacillus botulinus* is an anaerobic organism—that is, it grows in the absence of air. It grows readily at 20 to 25 degrees centigrade, but only sparingly at 37 degrees centigrade, the temperature of the body, and there is no conclusive evidence that it produces its toxin to any extent in the digestive tract of animals. *Bacillus botulinus* does grow readily and produces its toxin in protein foods such as meat or fish products. Some investigators state that it also produces its toxin readily in protein-containing vegetables like peas, beans, and corn. When growing in these foods, the organism produces a very powerful poison which produces the symptoms mentioned above, or even death, when eaten in extremely small amounts. Fortunately, cases of botulism are not common in this country.

The *Bacillus botulinus* is a spore-forming organism, but both the organism and its spores are not very resistant to heat, the spores being killed by heating to 80 degrees centigrade for one hour. The toxin which the organism produces is also destroyed by boiling. Thorough cooking at the boiling temperature is therefore all that is necessary to kill the organism and destroy its toxin in the food, and cases of botulism are due to the eating of food which has been infected with the organism and not been sufficiently cooked. Sausages, which might become infected with this organism, present ideal conditions for its growth, and have been a frequent cause of botulism. From this fact the name of the disease is derived. Infected meat products and, in a few instances, canned vegetables and fruits have been given as causes of botulism.

Recently Dr. Dickson of San Francisco has reported\* a study of eleven outbreaks of food poisoning, occurring during the past eighteen years in California, which he attributes to eating canned vegetables and fruits.

\* Journal American Medical Association, Vol. LXIX (1917), No. 12, pp. 966-968.



In these cases no definite information is available as to the methods used in canning the vegetables, but it is reasonable to assume that the contamination of the goods might have been brought about by the selection of food of poor quality for canning, by lack of cleanliness in packing the products, by the neglect of some essential steps in the process, or by failure of the heat to penetrate to all parts of the can in sterilization.

There is no danger that the type of food poisoning known as "Botulism" will result from eating fruits or vegetables which have been canned by any of the methods recommended by the United States Department of Agriculture, providing that such directions have been followed carefully, and that no canned goods are eaten which show signs of spoilage. In case of any doubt as to whether the contents of a particular can have spoiled it should be thrown away. If fed to chickens or other animals it should be boiled. No canned food of any kind which shows any signs of spoilage should ever be eaten. In the coldpack method of canning given out by the Department of Agriculture, only fresh vegetables are recommended for canning, and sterilization is accomplished by the following processes: Cleansing, blanching, cold-dipping, packing in clean, hot jars, adding boiling water, sealing immediately, and then sterilizing the sealed jars at a minimum temperature of 212 degrees Fahrenheit for one to four hours, according to the character of the material. Since the spores of *Bacillus botulinus* are killed by heating for one hour at 175 degrees Fahrenheit† there is no reason to believe that the *botulinus* organism will survive such treatment.

The *Bacillus botulinus* has been found in the digestive tracts of some animals, especially the pig and the fowl, probably occurring there in the same manner as does the organ-

ism of tetanus (lockjaw) in the intestinal tract of the horse. It is not a parasite in the ordinary sense, but rather a saprophyte. From these sources it may be deposited on the soil, although attempts at isolating it from the soil have generally given negative results.

### WARNING AGAINST MEDICINE FRAUD.

Imposters posing as Federal employees are trying to sell rheumatism and other "cures" which they represent to the gullible as being made by the United States Government, is a warning issued today by the Bureau of Chemistry, United States Department of Agriculture. Letters received from residents of Minnesota and South Dakota tell of such misrepresentations by agents of the "United States Medical Dispensary" or "Dr. Henry Post," Washington, D. C. The packages and labels guaranteed for \$20 "cures" for various ailments, but failed to give any address of those who are to refund. Federal inspectors have been unable to locate any such concern or doctor in Washington or elsewhere.

The label contains a serial number and states that the "product" is "guaranteed by Dr. Post under the national pure food and drugs act of June 30, 1906." The number given is that assigned to a concern which has never made such a product and has no connection with Dr. Post or a Dr. George Lawrence of South Dakota, who, according to a correspondent, represented himself as both Dr. Post's agent and an employee of the United States Government.

The department's inspectors cannot find that the product is being shipped in interstate commerce, which would bring it under the Food and Drugs Act and are of the opinion that the agents carry it personally to escape detection by the Federal authorities. The department, therefore, has brought the matter to the attention of various state and city food and drug officials with the view of securing their cooperation in detecting and preventing such fraudulent practices.

† Rosenau, M. J., Preventive Medicine and Hygiene, New York and London, 1917, 2d ed., p. 627; Jordan, E. O., A Text-Book of General Bacteriology, Philadelphia and London, 1916, 5th ed., p. 356; Park, W. H., and Williams, Anna W., Pathogenic Microorganisms, New York and Philadelphia, 1917, 6th ed., p. 449.

## Cancer Department

*"In the early treatment of cancer lies the hope of cure"*

AMERICAN SOCIETY FOR THE CONTROL OF CANCER

### VALUABLE STATISTICAL STUDY MADE POSSIBLE BY THE WAR.

The following extracts from the statement of Dr. J. A. Murray, director of the Imperial Cancer Research Fund, in the Fifteenth Annual Report of the Fund, 1916-1917, will be of interest to those engaged in the study of cancer statistics:

"The importance which has always been attached by statisticians to the age-constitution of populations in which cancer mortality has to be studied, receives striking justification by the results recorded in the 18th Report of the Registrar-General (1915) published this year. The withdrawal of a large number of young men from civil life constitutes a most valuable statistical experiment, showing the effects of a sudden alteration in the age-constitution of a population."

\* \* \* "The majority of the men withdrawn from civil life are under 35 years of age, and the cancer mortality figures for 1915 show the effects on a population of retaining the female sex in its normal proportions, while profoundly altering the relative proportions of the males above and below the age at which cancer is an important cause of death." \* \* \* "The change in the male population is on a large scale, affecting the whole country, and has taken place abruptly. It is analogous to those minor differences in age-constitution which have been attained slowly in isolated communities, and which go far to account for the phenomena of cancer villages and cancer streets. \* \* \* It is obvious that the varying conditions in limited areas at the present time must produce anomalies, and in fact, in some districts the deaths of males from cancer equal, or even exceed, those of females. Without the data necessary to effect the corrections for age and sex, crude death-rates for such limited

areas can only be misleading and may cause unnecessary alarm and distress.

"Undue importance should not be attached to the interruption in 1915 of the steady yearly increase of cancer mortality, the first since 1907. The conditions are abnormal, and as was pointed out in the Annual Report two years ago, the dislocation and diminution of the civil medical service by war conditions, may well affect the fidelity with which the national mortality figures reflect the absolute incidence of such a disease as cancer."

---

### YOUNG PHYSICIANS, YOUR OPPORTUNITY.

Never again in the history of medicine in this country will such an opportunity be afforded you to serve your country as well as the best interest of yourself.

The experience which you will gain by being commissioned in the Medical Reserve Corps and seeing active service, will be worth more to you in a professional way than you could acquire in years of practice in civil life.

The pay granted to officers in the Medical Reserve Corps is sufficient not only to cover all needs, but enable you to lay aside a comfortable balance, and while the older men in the profession have come forward, it is to the younger men that the greatest benefits accrue.

The experience will prove broadening both professionally and mentally. With this experience and the thought that you have served your country in time of need, you will return to civil life and receive the further benefits from your patients, friends and acquaintances, always accorded to one who has been so prominently individualized as this opportunity will afford you.

MINUTES OF MEETING OF ESCAMBIA COUNTY (FLA.) MEDICAL SOCIETY, DECEMBER 11, 1917.

The society was called to order by the president, Dr. Blocker. The following members were present: Drs. Blocker, Bryans, Payne, Thompson, Nobles (Wm. D.), and Brink.

The minutes of the previous meeting were read and approved.

There was no paper to be presented at the meeting, so the election of officers for the ensuing year was taken up and the following were elected. The secretary was instructed in each instance to cast the unanimous ballot of the society for the candidate, as there was but one nominee for each office:

President—L. de M. Blocker.

Vice-President—Wm. D. Nobles.

Secretary—F. A. Brink.

Treasurer—W. C. Payne.

The report of the treasurer was made by the secretary, the treasurer having joined the colors. This report shows a balance of \$66.03 in the treasury. Report received and filed.

The following resolutions were offered and adopted:

(1) Providing that this society offer to pay the state association \$1.50 for each member who is absent on military duty, provided the state association will accept this amount in lieu of the regular annual dues of \$3.00, and apply this amount toward the maintenance of THE JOURNAL.

(2) Providing that the society shall meet once a month on the second Tuesday of the month, instead of on the second and fourth Tuesdays, as heretofore.

(3) Providing that the January meeting be a joint meeting with the dentists; that the medical men of the Army and Navy be invited, and that refreshments be provided.

Society adjourned.

F. A. BRINK,  
Secretary.

ACTION OF THE STATE COMMITTEES OF THE MEDICAL SECTION, COUNCIL OF NATIONAL DEFENSE

URGING IMMEDIATE ACTION PROVIDING FOR AT LEAST SIX MONTHS OF INTENSIVE MILITARY TRAINING OF ALL YOUNG MEN IN THEIR NINETEENTH YEAR, TO BECOME OPERATIVE AS SOON AS THE ARMY CANTONMENTS ARE AVAILABLE; ALSO RECOMMENDING PHYSICAL TRAINING IN SCHOOLS, ETC.

The following resolutions were adopted unanimously at a meeting of committees from all states (except Maine and Delaware), held in the Congress Hotel, Chicago, October 23, 1917:

*Whereas*, the experience through which the United States is now passing should convince every thoughtful person of the necessity for the universal training of young men, not only for the national defense in case of need, but also to develop the nation's greatest asset — its young manhood — in physical strength, in mental alertness and in respect for the obligations of citizenship essential in a democracy; Therefore, Be It

*Resolved* by the State Committees of the Medical Section of the Council of National Defense that they strongly urge the adoption by our government at this time of a comprehensive plan of intensive universal military training of young men for a period of at least six months, upon arriving at the age of nineteen years; and that this body also support the movement to secure the introduction into public schools of adequate physical training and instruction;

*Resolved*, That the members of each State Committee immediately take active steps to insure public support for the subject of these resolutions through the newspapers, through public meetings, and through the appointment of committees in each county; also that copies of these resolutions be forwarded to the Senators and Members of Congress in their respective states, with a personal request that favorable action be taken at the



coming session of Congress upon a measure following the principle of the Chamberlain bill and to become operative as soon as the army cantonments are no longer required for the training of the forces in the present war.

*Resolved*, That each State Committee from time to time report to the Medical Section of the Council of National Defense as to action taken and progress secured in their several states.

#### NOTICE.

The undersigned having been assigned to duty at the Base Hospital, Camp Joseph E. Johnston, his work in connection with the organization of this hospital has been such as to allow a minimum of time in getting this issue of The Journal off the press. The Editorial Department and the column "Medico-Military Jottings" has therefore received no attention this month. It is anticipated that both these departments will receive attention in our next issue.

GRAHAM E. HENSON,  
Secretary-Editor.

## Publisher's Notes

### CLINICAL DATA ON "DICHLORAMINE-T."

The Official Bulletin of the United States Government, published daily under order of the President by the Committee on Public Information, states, in the issue of October 31, 1917: "Many matters of importance touching upon American cooperative effort and activity along medical and surgical lines were developed during the past week in Chicago, when the general medical board and the States activities committee of the medical section of the Council of National Defense held stated meetings in conjunction with the annual meeting of the Clinical Congress of Surgeons of North America.

"Addresses were made by Dr. Edward Martin, Dr. E. K. Dunham and Dr. W. E. Lee, all of Philadelphia.

"By means of a moving-picture demonstration and the detailing of experimental and clinical data, they showed how much

could be done for clean wound healing by the new antiseptic, Dichloramine-T, which is being investigated under instructions from the Surgeon General's Office."

Dr. W. E. Lee, of the Pennsylvania Hospital, reported 1,288 surgical cases in which "Dichloramine-T" was used with remarkable results. He also reported twelve hundred war wounds treated in France with "Dichloramine-T" with 99.5 per cent recoveries and no secondary hemorrhages.

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OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV  
No. 7

St. Augustine and Jacksonville, Fla., January, 1918

Yearly Subscription, \$1.50  
Single Copy, 15c.

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, January, 1918

Number 7

## ORIGINAL ARTICLES

### THE ANATOMY OF THE BLADDER.\*

FREDERICK J. WALTER, M. D.,

Daytona, Fla.

In a symposium for the discussion of cystitis it is well to begin at the beginning and review the anatomy of the bladder and adnexa. The bladder is the reservoir for the urine. It is essentially a musculo-membranous sac situated behind the pubes, and in front of the rectum in the male, the uterus and vagina intervening between it and that intestine in the female. It is important to remember that the position, shape and relations are greatly influenced by age, sex and the degree of distention of the organ. In infancy it is conical and projects above the upper border of the pubic bone into the hypogastric region. In the adult, when it is quite empty and contracted, it is a small triangular sac, placed deeply in the pelvis, its apex reaching as high as the upper border of the symphysis pubis. When slightly distended, it is rounded in form and still within the pelvic cavity; and when greatly distended, it is ovoid in shape and, rising into the abdominal cavity, often extends nearly as high as the umbilicus. The bladder is longer in the vertical diameter than from side to side. It is more convex behind than in front. In the female it is larger in the transverse than in the vertical diameter. It is somewhat of a question as to the comparative size of the male and female bladder. The bladder is divided into summit, body, base and neck. The summit is the apex and is rounded, directed forwards and upwards; it is connected with the umbilicus by a fibromuscular cord, the urachus. The summit behind the urachus is covered with peritoneum

while the portion in front of the urachus has no peritoneal covering, but rests against the abdominal wall. The urachus is the obliterated remains of a tubal canal which exists in the embryo and connects the cavity of the bladder with a sac external to the abdomen, opposite the umbilicus which is called the allantois.

In the infant at birth the urachus is occasionally found pervious, so that the urine escapes at the umbilicus, and calculi have been found in the canal. The body of the bladder is not covered in front by peritoneum, but is in relation with the triangular ligament, the posterior surface of the symphysis pubis, the internal obturator muscles and when distended, with the abdominal parietes. The posterior surface is covered with peritoneum. It corresponds in the male, with the rectum; in the female, with the uterus, some convolutions of the small intestines being interposed. The side of the bladder is crossed obliquely from below, upward and forward, by the obliterated hypogastric artery; above and behind this cord the bladder is covered by peritoneum, but below and in front of it this covering is wanting, and it is connected to the pelvic fascia. The vas deferens passes in an arched direction along the sides of the bladder at the inner side of the ureter. The fundus or base of the bladder is directed downwards and backwards. In the male it rests upon the second portion of the rectum. In the female the base lies in contact with the lower part of the cervix uteri, is adherent to the anterior wall of the vagina, it is separated from the upper part of the anterior cervix by a fold of peritoneum. The neck of the bladder is the point of commencement of the urethra, it is not tapering but suddenly con-

\*Read before the Volusia County Medical Society at Daytona, October, 1917.



tracts to the opening of the urethra. In the male its direction is oblique in the erect posture and is surrounded by the prostate gland. In the female its direction is obliquely downwards and forward.

The bladder is retained in place by ligaments which are divided into true and false. The true ligaments are five in number: two anterior, two lateral and the urachus. The false ligaments are the five formed by folds of the peritoneum. The *anterior ligaments* (pubo-prostatic) extend from the back of the pubic bone on each side of the symphysis, to the front of the neck of the bladder, over the upper surface of the prostate gland. The lateral ligaments from the recto-vesical fascia are broader and thinner than the anterior ligaments. They are attached to the sides and base of the bladder and to sides of the prostate. The urachus we have mentioned is broad below and is narrower as it ascends.

The false ligaments are two posterior, two lateral and one superior. The two posterior pass forward, in the male from the sides of the rectum; in the female from the sides of the uterus to the posterior and lateral aspect of the bladder; here they contain the obliterated hypogastric arteries and the ureters, together with vessels and nerves.

The two lateral ligaments are reflections of the peritoneum from the iliac fossæ to the sides of the bladder. The superior ligament is a prominent fold of the peritoneum extending from the summit of the bladder to the umbilicus. It covers the urachus and the obliterated hypogastric arteries. The coats of the urinary bladder will be discussed under the histology of this organ.

## TREATMENT OF THE CYSTITIS OF THE AGED.\*

JOHN REEVE, M. D.,  
DeLand, Fla.

The stigmata, or marks, of degeneration in the physical system are generally well marked.

We have webbed fingers, webbed toes, cleft-palate and harelip, and Darwin says that the vermiform appendix is a sign of degeneracy and that it is merely a rudimentary tail. If this is so, it would save us a great amount of trouble if it were on the outside where tails usually are.

A number of years ago the thyroid and prostate glands were in the same category, but when it was discovered that they both had functions, they naturally dropped out.

We do not know the cause of prostatic hypertrophy, but we do know that its presence interferes with a function of most vital importance. The same may be said of thyroid hypertrophy.

Hypertrophy of the prostate gland is usually the first etiological factor in the disease we are about to consider, "Cystitis of the Aged." It usually occurs in men at, or about, fifty, occasionally before, but it is generally considered a disease of comparatively old age. It is a gradual, painless enlargement, and may have attained quite a size without the knowledge of the patient, early symptoms being obscure or absent.

What he notices first is a desire to empty his bladder two or three times during the night. During the day, he notices that he has to urinate oftener than usual, and also that, at times, the call is urgent and imperative. He also becomes conscious of the fact that the stream does not start promptly, has lost its projectile force and power, and after a time will drop straight down between his feet. He may, and possibly does, think that these abnormalities are perquisites peculiar to his time of life, with which he would willingly dispense.

This is the first stage of hypertrophy, but ordinarily we have no cystitis at this time.

The second stage is about the same as the first, only the symptoms are more pronounced, and, in addition, we have what is called residual urine, which means that notwithstanding the numerous attempts, the bladder is never entirely emptied, and the retained urine, gradually increasing from

\*Read before the Volusia County Medical Society at Daytona, October, 1917.

day to day, becomes the second etiological factor of cystitis, which, however, may not yet be present.

In what is called the third stage of hypertrophy, from various causes, we may have retention, sudden and complete, and it is usually this retention and the means used to relieve it which are the exciting causes producing cystitis.

Of course we may, and do, have retention which is relieved by the catheter, two or three times a day in skilled hands, for an indefinite period, with satisfaction and comfort, but sooner or later the catheter gets into the hands of the patient and then the symptoms change, and we have cystitis with its three most prominent symptoms—painful urination, or attempts at it, with tenesmus and straining.

What can we do for this condition?

Empty the bladder at once, and examine carefully what you get, its quantity, its color, reaction and specific gravity; notice if it contains pus or blood or albumin; think of the possibility of stone, and prescribe for what you find.

Perfect rest is imperative. Moist heat to the region of bladder is useful, if there is much pain with tenesmus. Codeine in half-grain doses three or four times a day or more, or hyposcyamus in some form is indicated. If the urine is too acid, give water in abundance with citrate or acetate of potash. If it is alkaline and ammoniacal, as it surely will be at times from the action of bacteria on the urea, benzoic acid, benzoate of sodium, formin, or sandal oil is used.

For irrigation, I have had much satisfaction from the use of a warm solution of boric acid, weak solutions of permanganate of potash are also much used; but don't do too much; there is always a tendency in that direction.

It is well to remember that in case of retention, where there is urgency, and a catheter cannot be passed, we can aspirate above the pubes into a full bladder with per-

fect safety, and as often as we please, with proper precautions.

Also that where a catheter can be passed, it may be tied in and left a reasonable time, in order to rest the bladder and thoroughly drain it. Not every patient can tolerate this, however.

The kind of catheters used is a point for consideration. A soft rubber catheter, a little longer than usual, will, under ordinary circumstances, meet all indications. If more power is needed, a silk woven catheter with the coude tip may be tried, or the different sizes of the same make of catheter without the coude, or the hard rubber variety, with or without the wire. But whatever form of catheter is used, the utmost patience and gentleness should be observed under all circumstances.

Treatment of this kind is only palliative, however, in this form of cystitis, because it does not remove the cause.

The predisposing cause is prostatic hypertrophy. The exciting cause is the catheter.

The operation for the removal or enucleation of the prostate — prostatectomy — had, for a number of years, a bad record, fifty per cent mortality made it almost prohibitory; but now, by improved technic, this has been reduced to five per cent, and one operator, who makes a specialty of it, publishes a list of one hundred and twenty-eight cases without a death. This, then is the scientific way of treating this disease, by removing the cause.

There may be, and usually is, sterility produced by the operation, from injury to the ejaculatory ducts, which is unavoidable, and with this class of patients, not of much consequence. Many of these old men, however, prefer a "catheter life" rather than the risk of operation, and they do so simply because they are old.

I was, at one time, so unfortunate as to have a patient who relied upon the catheter entirely for twelve years. He was perfectly useless, mentally and physically. Would not hear of an operation, and was never happy

except when he was drunk. Many times he wished fervently that he was dead, and so did I.

Referring to catheters and their uses brings to mind a case in point:

Sometime ago I was called in consultation with Dr. Davis of DeLand to see a man of about sixty, an engine driver, who had had prostatic hypertrophy for several years, and who had been seized with a sudden attack of retention. Dr. Davis informed me that he had entirely failed to pass a catheter, of any kind whatever, and so after repeated attempts, did I, and we were about to aspirate above the pubes, when the patient incidentally remarked that two years before, during a similar attack, his urine had made a false passage and escaped behind the scrotum. We at once investigated and found the fistulous tract, and with very little trouble introduced a small soft rubber catheter through it and into the bladder, draining it thoroughly and leaving it there for a time.

Neither Dr. Davis nor myself had any precedent for a procedure of this kind, but it is well to be enterprising in cases of emergency.

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## HISTOLOGY OF THE PROSTATE AND BLADDER.\*

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The urinary bladder is composed of four coats: serous, muscular, sub-mucous and mucous.

The serous coat is only partial and is a part of the peritoneum. It invests the superior and lateral surfaces and base, being reflected from these surfaces onto the abdominal and pelvic walls.

The muscular coat is composed of unstriped muscular fibres and distributed in three layers. The external arranged longitudinal; the middle circular and the internal with the fibres arranged longitudinal. The

outer or thicker layer has at the sides of the bladder the fibres arranged obliquely interlacing with one another. The fibres are thin in the middle coat except at the lower end where they surround the beginning of the urethra where they are in a heavy band. The inner coat is composed of thin layers of fibres.

The submucous coat is a layer of areolar tissue binding together the muscular and mucous coats.

The mucous coat is thin, smooth and of a pale rose color. It is a continuous membrane from kidney to external opening of urethra. The areolar tissue of the submucous coat loosely joins the mucous to the muscular coat.

A transitional variety of epithelium covers the surface of the mucous coat. The superficial layer of polyhedral flattened cells, each with one, two or three nuclei, covers a stratum of large club-shaped cells containing an oval nucleus. There are no true glands in the mucous membrane of the bladder, though certain mucous follicles which exist especially near the neck of the bladder have been regarded as such.

The prostate is composed of fibrous, muscular and glandular tissue. The gland is enclosed in a thin but firm fibrous capsule.

Muscular tissue constitutes the greater part of the organ, forming the stroma proper and holding in its meshes the glandular tissue. The muscular tissue first surrounds the gland beneath the capsule, then decussates, forming little meshes through the organ to support the glandular substance.

The glandular substance composes numerous follicular pouches opening into elongated canals, which when united form the excretory ducts. The follicles are held together by areolar tissue and this supported by the prolongations from the fibrous capsule and muscular stroma are all enclosed in a delicate capillary plexus. Columnar epithelium line both the canals and the terminal vesicals.

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\*Read before the Volusia County Medical Society at Daytona, October, 1917.



## PHYSIOLOGY OF THE KIDNEYS.\*

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The principal excrementitious fluids discharged from the body are urine, perspiration and bile. They hold in solution principles of waste which are generated during the activity of the nutritive process, and are the ultimate forms to which the organic constituents are reduced in the body. They also contain inorganic salts.

Possibly the most important of this group is urine. The kidneys are the organs for the secretion of urine. They resemble a bean in shape, are from four to five inches in length, two in breadth, and weigh from four to six ounces; are situated in the lumbar region, extending from the eleventh rib to the crest of the illeum.

The kidney is a compound tubular gland composed of microscopical tubules whose function it is to secrete from the blood those waste products which collectively constitute the urine.

The average quantity of the principal constituents excreted in twenty-four hours is as follows: Water, 52 ounces; urea, 512.4 grains; uric acid, 8.5 grains; phosphoric acid, 45 grains; sulphuric acid, 31.11 grains; inorganic salts, 323.25 grains, and magnesia, 6.5 grains.

As the kidney anatomically presents an apparatus for filtration (the malpighian bodies) and an apparatus for secretion (the epithelial cells of the urinary tubules), it might be inferred that the elimination of the constituents of the urine is accomplished by the twofold process of filtration and secretion; that water and highly diffusible inorganic salts simply pass by diffusion through the walls of the blood vessels of the glomerules into the capsule of Muller, while the urea and remaining organic constituents are removed by true secretory action of the renal epithelium. The secretion of urine is, therefore, partly physical and partly vital.

The filtration of urinary constituents from the glomerules into Muller's capsule depends largely upon the blood pressure and the rapidity of blood flow in the renal arteries and glomerules.

Among the influences which increases the pressure and velocity may be mentioned increased frequency and force of the heart action, contraction of the capillary vessels of the body generally, dilatation of the renal artery, and increase in the volume of blood. The reverse conditions lower blood pressure and diminish the secretion of urine.

The fact that organic matters are eliminated by the secretory activity of the renal epithelium seems to be well established by modern experiments. These substances removed from the blood in the secondary capillary plexus of blood vessels by true selective action of the epithelium are dissolved and worked towards the pelvis by the liquid coming from the capsules.

The blood supply to the kidneys is regulated by the nervous system. If the renal nerves be divided, the renal artery dilates and a copious flow of urine takes place. If the peripheral ends of the same nerves be stimulated the artery contracts and the urinary flow ceases. The same is true of the splanchnic nerves, through which the vasomotor nerves pass to the renal plexus. As soon as urine is formed it presses through the tubuli uriniferi into the pelvis of the kidneys, thence through the ureters to the bladder which it enters at an irregular rate. Shortly after a meal, after the injection of a large quantity of fluid, and after exercise, the urine flows into the bladder quite copiously, while it is reduced to a few drops during the interval of digestion.

When the urine has passed into the bladder, it is there retained by the sphincter vesicæ, kept in a state of chronic contraction by the action of a nerve center in the lumbar region of the spinal cord. This center can be inhibited and the sphincter relaxed either reflexly by impressions coming through the sensory nerves from the mucus membrane

\*Read before the Volusia County Medical Society at Daytona, October, 1917.

of the bladder, or directly by a voluntary impulse descending the spinal cord. When the desire to urinate is experienced, impressions made upon the vesical sensory nerves are carried to the centers governing the sphincter and detrusor muscles and thence to the brain.

When the bladder is emptied by volition, a voluntary impulse originating in the brain passes down the spinal cord and inhibits the sphincter vesical center with the effect of relaxing the muscle and stimulating the center governing the detrusor muscle, with the effect of contracting the muscle and expelling the urine. The nerve center controlling these movements is in that portion of the spinal cord corresponding to the origin of the third, fourth and fifth sacral nerves.

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### CYSTITIS COMPLICATING ENLARGED PROSTATE.\*

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Usually when considering conditions resulting from enlarged prostate, the hypertrophy that comes with advancing years is what we think of. There may be inflammatory conditions of the prostate that lead to enlargement and cause cystitis, even though the organ may not make marked obstruction to the outflow of urine. These inflammations are usually specific in character, but may be due to other causes. Cancer of the prostate with ulceration may also lead to cystitis.

But the condition I am expected to discuss is, I take it, cystitis following chronic or senile hypertrophy. The enlargement of the gland causes an obstruction at the outlet of the bladder and thus prevents the viscus from completely emptying itself. The condition of residual urine may exist for a long time without causing inflammation of the bladder. Sooner or later, however, chemical changes or bacterial invasion will cause a cystitis.

The chemical changes affect the mucous

membrane in two ways. There may develop conditions that will irritate the bladder lining in an individual whose mucous membrane is sensitive, simply by the chemical changes in the residual urine. More frequently, however, the chemical changes result in the formation of stones. These become a source of irritation and cause a form of cystitis. Whether this results without the invasion of bacteria is doubtful.

When cystitis results from an enlarged prostate, it is usually due to bacterial invasion. Sometimes the bacteria are brought to the viscus through blood channels. Some claim the colon bacillus may pass directly through the tissues of the intestine into the bladder. It seems more reasonable to me, if the germs can escape from the intestine, that they would get into the circulation through the capillaries or lymph spaces in the intestinal wall and invade the mucous membrane of the bladder from the capillaries of its wall. Or they may be eliminated via the kidneys and find a hot bed for development in the bladder, where residual urine has weakened resistance and fertilized the tissues for bacterial development.

However, the usual way by which bacteria get into the bladder is by the use of the catheter. Even with due care in sterilization of the catheter and the penis, there are likely to be bacteria in the distal portion of the urethra that are carried into the bladder. Once there the residual urine, as mentioned before, makes a favorable soil for their development.

While we recognize the fact that the cystitis following an enlarged prostate is directly or indirectly due to the obstruction that interferes with the complete emptying of the bladder, I am convinced, from my observation of these cases, that idiosyncrasies of individuals is an important factor. Probably all of us have seen cases with residual urine of long standing in which the catheter had been used without thorough asepsis, and yet without the development of cystitis. Also cases in which stones complicated the pros-

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\*Read before the Volusia County Medical Society at Daytona, October, 1917.

tate hypertrophy and in which little, if any, inflammatory trouble developed. In other cases, bladder irritation and inflammation were early and prominent symptoms. I call attention to these facts for the reason that many of these patients are not able to have the rational treatment for hypertrophy of the prostate, namely, surgical removal. I believe that general treatment will often raise the resistance and mitigate the suffering.

### TREATMENT OF CYSTITIS.\*

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Before entering upon the treatment of cystitis, it is very necessary to examine the urine both chemically and microscopically and of recognizing the presence of any substances irritating to the vesical mucosa, as oxalate or uric acid crystals.

The removal of any urinary irritation is essential to the speedy cure of the cystitis. Rest in bed is not desirable, especially in cystitis due to venereal causes, and in cases of partial urinary retention it seems to favor rather than lessen pelvic congestion.

Regular daily exercise in the open air, in accordance with the strength of the patient, is to be commended.

The diet must be so regulated that digestion is perfectly performed, for even slight gastric or intestinal disorders render the urine distinctly irritating.

Usually diluent drinks are serviceable, especially at night. Natural mineral waters may be given in accordance with the dyscrasia of the patient. Careful attention should be given the skin — patient should be bathed daily in either hot or cold water as preferred.

The cabinet baths may be used daily if it doesn't produce weakness or debility, being followed by a cool sponging and vigorous friction. I have found the common ordinary sitz bath very efficacious at times in relieving that urgent desire to urinate. Regular evacua-

tion of the bowels must be insisted upon, as rectal obstruction is always followed by the appearance of enormous numbers of colon bacilli in the urine, coming either from the kidneys or through the intervening walls of the bowel. Mild salines, rectal enemas, the nightly ingestion of one ounce of a paraffin oil will usually keep the bowels empty. In treating an acute cystitis of severe form, rest in bed, hot baths, elevation of hips and thorough evacuation of the lower bowel best procured by salines and cold salt-water enemas, are recommended. For the relief of the frequent and painful urination, belladonna and opium suppositories are indicated and should be given every hour or two until pain is relieved.

Hot compresses to the abdomen, changed frequently, help to relieve pain. Diluents and sedatives should be given by mouth. If the urine is strongly acid, copious draughts of water with either citrate or acetate of potassium in ten-grain doses should be given about six times daily. Salol and boric acid should be given to render urine slightly antiseptic. In my hospital work I have had excellent results especially in acute cases of cystitis by placing my patients in bed and irrigating the bladder with a normal salt solution and injecting about two ounces of a ten-to-twenty per cent argyrol solution and insisting upon the patient retaining same as long as possible. I have relieved patients suffering severe pain by this method in from six to twelve hours without any other medication.

### TUBERCULOSIS OF THE BLADDER.\*

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This distressing affection usually follows tubercular infection in some other part of the urinary tract and most commonly the kidney is the primary focus, though the tubercle bacilli may reach the bladder from some re-

\*Read before the Volusia County Medical Society at Daytona, October, 1917.

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more part of the body via the blood or lymph channels or even from without as the result of cohabitation or catheterization. Traumatism of the bladder or other disease conditions in adjacent tissues seem to make this trouble more frequent. The various pus-producing germs usually find an early entrance to the bladder, thus adding a tuberculous cystitis. The primary lesion is that of the gray tubercle in the mucous membrane surrounded by an area of pink congestion. These are usually seen on the trigone near the mouth of one of the ureters. Later they ulcerate, though usually they are superficial. The ulcers may cover a large portion of the bladder wall, and a certain amount of granular and scar tissue may occur. Deep or perforating ulcers are rare, though a pericystitis may occasionally be found. Like most forms of cystitis, the principal symptoms are pain, frequent urination and tenesmus, accompanied by hæmaturia in about 20 per cent of the cases. Secondary infection increases the trouble and the greatest amount of pain and frequency of urination is usually found when there is ulceration over the vesical sphincter. Distension of the bladder causes suprapubic pain; during urination it is in the glands, and on completion of the act it is in the neck of the bladder. The urine is usually abundant, of low specific gravity and contains a small amount of albumin and hyaline casts in addition to bladder epithelium and pus. Intestinal nephritis and cystitis from other causes will produce these urinary findings, and as the T. Bacilli cannot usually be found microscopically, we must make the diagnosis by other means than urinalysis. Cystoscopic examination is the best aid to diagnosis when the bladder will tolerate enough water to distend it properly and bleeding is absent or can be stopped long enough to keep the water clear. Much diagnostic aid may be gotten from the inoculation of guinea pigs with suspected urine as well as a thorough examination of the rest of the body in search of a primary focus.

T. B. of the bladder occurs most often be-

tween the ages of fifteen and thirty-five. As between T. B. of the bladder and calculus: Frequent urination and pain are marked during the day in calculus, but much better at night, while there is little difference in T. B. of the bladder. Also the radiograph and searcher are useful in cases of stone and guinea pig inoculation in cases of T. B. of the bladder. Bladder tumor produces less distress and later cachexia as a rule, though hæmaturia is more abundant and fragments of tumor may often be found in the urine; stricture and enlarged prostate produce urinary disturbance as a result of obstruction. Stricture produces narrowing of the urethra at one or more points and pain and frequent urination is not so marked as in the tubercular condition. Prostatic enlargement may be felt by rectal examination and produces residual urine, while T. B. cystitis seldom occurs after thirty-five or forty years of age. Prostatic enlargement does not often occur until after fifty years. The general treatment is very much like that of any other tubercular condition: Light woolen clothing, moderate exercise in good weather, and avoidance of draughts. It is best to wear a rubber urinal during the day and have a glass one convenient at night. A simple diet, from which is excluded fried meats, most sweets and all condiments and alcoholic beverages, should be adopted. Guiteras advises 3 grains carbonate creosote T. I. D. and syr. femi iodide 15 m. between meals. Urotropin, salol or sodium benzoate is commonly used as a urinary antiseptic. For the pain tr. belladonna, sodium bromide, codeine or morphine may be needed according to the degree of suffering locally. Four per cent boric acid solution makes a good cleansing wash. Argyrol 10 to 25 per cent may be used, or nitrate silver sol. 1-800 to 1-1000, especially after first using the argyrol solution. Guaiacol 10 c. c. of 50 per cent solution daily, or iodoform emulsion 2 per cent, to be retained in either instance. The various cystotomy operations usually leave the patient worse than at the beginning.

## ETIOLOGY AND PATHOLOGY OF CYSTITIS.\*

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Cystitis is an inflammation of the bladder caused by microorganisms. These organisms are principally: the colon bacillus, the urobacillus, bacillus of tuberculosis, or the coccus of gonorrhœa, the streptococcus and the staphylococcus pyogenes. Cystitis, therefore, is to be distinguished from simple hyperæmia in which there is no evidence of infection, and also from frequent urination caused by some irritating substance in the urine or by nervousness.

Cystitis may be latent, when, *e. g.*, a pelvic operation or a confinement forces it into evidence; or acute, when the onset is sudden, the symptoms intense, but the duration short; or chronic, generally the sequel of the acute inflammation. In some cases it is mild, in others intense enough to make life a burden. The affected part of the bladder may be its fundus, but more frequently its posterior wall, or the region of the trigone, and may later spread all over.

The most common source of the infection in cystitis is the urinary catheter introduced at a time when the resisting powers of the patient are reduced by confinement or pelvic operation or other causes. The parts of the urinary canal adjacent to the external orifice of the urethra are normally the habitat of a profuse bacterial flora, especially of the colon bacillus, and an infection which, in normal health would be easily thrown off, cannot be resisted when the powers of the body are lowered.

If no catheter has been used, and the cystitis, even when mild, is of long standing, the suggestion of tubercular kidney is given, as primary tuberculosis of the bladder is rare. In other cases of cystitis the gonococcus is the principal cause of infection, the urine is acid in reaction, but may be alkaline in the

presence of the urobacillus, which decomposes urea with the formation of ammonia. Also the typhoid bacillus and the pneumococcus can cause cystitis. Exposure to cold is sometimes considered as a cause, but can at most be so indirectly by lowering the vitality of the tissues and predispose the bladder to the entrance of the bacteria. The germs may reach the bladder through the urethra, or with the urine from the kidneys; also by way of the blood vessels, when, for instance, an infected embolus reaches the bladder, or by way of the lymphatics from adjacent organs as the ovaries and uterus.

The disease usually affects first the mucous membrane of the bladder and after a time may involve the muscular, subserous and even the serous coats.

As seen through the cystoscope, the mucous surface in a case of cystitis is no longer smooth but appears ragged with adherent flakes of lymph, the epithelium becoming eroded. The erosions become deeper, sometimes forming ulcerations. The color is at first bright red, with branching lines which mark the course of the blood vessels. Later the blood oozes through capillary ruptures, and the blood pigment colors the surface slate to black.

In very septic cases the mucous membrane sloughs in patches, and hangs in shreds from the wall. Minute abscesses may form in the muscular layer. The vascular degeneration may lead to fibrous induration and sclerosis of the bladder wall, which becomes thicker, loses its elasticity and contracts the cavity. Thereby it falls in folds which makes the emptying of the bladder difficult, even with a catheter. The spaces between the folds stretch into sac-like dilations without muscular fibres, covered only by the serous membrane, and become filled by stagnant urine. Or, on the other hand, the vascular degeneration may make the bladder wall thin and placid, and the cavity becomes distended to a much greater capacity than normal.

Sometimes when there is intense sepsis and great pressure on the blood vessels, the

\*Read before the Volusia County Medical Society at Daytona, October, 1917.

circulation is shut off, gangrene follows, and on the wall of the bladder a false membrane may form, which is thrown off as a coat. The microscope shows such a slough to be an entangled mass of epithelial cells, lymphocytes, urinary salts and microorganisms.

### PROPAGANDA FOR REFORM.

ANOTHER SHORTAGE OF SALVARSAN.—The indications are that the supply of salvarsan and neosalvarsan in this country has again reached the point of exhaustion. Congress, which made our patent law, has the power to suspend the patent on any preparation that the patentee is unable to, or does not supply, when such suspension is in the interest of public health, and it should suspend the salvarsan patent. In the meantime it is to be hoped that the Dermatologic Research Laboratory of Philadelphia will again supply the product as it did during the previous salvarsan shortage. (*Jour. A. M. A.*, March 10, 1917, p. 785.)

BINIODOL.—The Council on Pharmacy and Chemistry reports that Biniodol is claimed by the manufacturer, Charles C. Yarbrough, Memphis, Tenn., to be a solution of 1 per cent mercuric iodid and 2.75 per cent guaiacol in a vegetable oil and that it is marketed with the implication that it is new and superior to other oil solutions of mercuric iodid. The Council found that the claims of novelty and of superiority were not substantiated by the evidence. Clinical investigation did not demonstrate the effects of Biniodol to be different from those of solutions prepared in the A. M. A. Chemical Laboratory, with and without guaiacol. The Council declared Biniodol inadmissible to New and Nonofficial Remedies because claims of superior efficiency were not established, and because it is an unessential modification of an established non-proprietary article marketed under a proprietary name. (*Jour. A. M. A.*, Feb. 24, 1917, p. 650.)

EFFECT OF OPIUM ALKALOIDS ON THE URETERS. — According to D. I. Macht,

morphin and the opium alkaloids having a similar constitution, increase the contraction and produce a greater tonicity of the ureter, whereas papaverin and the opium alkaloids, constituted similarly, produce a slowing or total inhibition of the contraction and relaxation of the tonus. In opium and pantopon, which contains the total alkaloids of opium, the effect of the morphin group preponderates. Ureteral colic is due to spasmodic contractions of the ureter caused by the irritating calculus and hence the use of papaverin or opium is more rational than that of morphin. Furthermore, the slighter toxicity of papaverin, its tonus lowering power and its local analgesic properties suggest its local application in spasmodic conditions of the ureter. (*Jour. A. M. A.*, March 3, 1917, p. 719.)

DATING OF BIOLOGIC PRODUCTS.—For the protection of the consumer as well as the manufacturer, the Council on Pharmacy and Chemistry has adopted a rule requiring that serums and vaccines and similar products to be accepted for New and Nonofficial Remedies must bear on each package the date of its manufacture in addition to the date required by federal law. The practice now followed by manufacturers of placing on the containers of biologic products the date beyond which these agents are not to be regarded as dependable (though in accordance with the federal law) has not been satisfactory. Except for diphtheria and tetanus and antitoxin, in general there are no methods for determining the potency of serums and vaccines. At the present time, for the same material, one manufacturer will fix an expiration date of four months, others one year or even eighteen months. Obviously this lack of uniformity is unfair to the manufacturer who endeavors to supply a product as fresh as is commercially practicable and it also may lead the physician to form a false opinion regarding the potency of certain biologic products. The new rule of the Council will enable the physician to know the age of a given prod-



uct when it reaches him and will permit him to judge whether or not it has been kept unduly long. Moreover, it will prove not only helpful to the conscientious manufacturer and the physician but will also safeguard the patient. (*Jour. A. M. A.*, March 3, 1917, p. 728.)

**ICHTHYTAR.**—The Council on Pharmacy and Chemistry reports that Ichthytar was submitted by the Szel Import and Export Company with the claim that it was essentially similar to ichthyol in composition and superior to it in therapeutic properties. The statements that were submitted regarding its composition made it impossible to determine whether or not it was similar to or identical with ichthyol. No evidence was furnished in regard to its therapeutic value. On the basis of the available information the Council held the claims regarding composition and therapeutic value unsubstantiated and ichthytar ineligible for New and Nonofficial Remedies. (*Jour. A. M. A.*, March 10, 1917, p. 796.)

**MORE MISBRANDED NOSTRUMS.**—The following "patent medicines" were found misbranded under the U. S. Food and Drugs Act chiefly because false and fraudulent therapeutic claims were made for them: Collins' Ague Remedy, admittedly containing 33 1/3 per cent alcohol. Swaim's Panacea, containing nearly 5 per cent alcohol, 58.5 per cent sugar, 0.1 per cent salicylic acid and some sarsaparilla. Swayne's Panacea, essentially the same as Swaim's Panacea in composition. Croxone, capsules containing a white pill and a red oil; the oil was oil of pine or oil of juniper dissolved in a fatty oil, while the pill consisted essentially of strychnine, a trace of brucine, aloin, hexamethylenamin, lithium carbonate, potassium nitrate and probably a trace of atropin. Freeman's Balsam of Fir Wafers, lozenges consisting of sugar with very small amounts of oil of turpentine and eucalyptus with the possible presence of balsam of fir. Renne's Pain Killing Oil, essentially a water-alcohol solution of sassafras oil and

cayenne pepper containing 78.6 per cent alcohol and 4 per cent volatile oils and possibly a little mustard oil and soap. Schuh's Yellow Injection, an aqueous solution of boric acid, carbolic acid and berberin. Schuh's White Mixture, a mixture of mucilage of tragacanth, balsam of copaiba, and probably sandalwood oil, flavored with cassia. Elmore's R'eumatine Goutaline, apparently a dilute tincture of colchicum. Armstrong's Croup Ointment, containing eucalyptus and traces of other oils, possibly cassia and thyme. Anticephalalgine, containing 30 per cent alcohol and 4 grains acetanilid to the ounce, sodium bromid, sodium salicylate, caffenin and antipyrin. Wright's Rheumatic Remedy, an emulsion composed principally of turpentine, methyl salicylate, sugar, acacia and water, with probably some resinous or plant extractive matter. H. G. C., a watery solution of borax and berberin sulphate. Russel's White Drops, containing 13 to 16 per cent of alcohol as well as codein. Pneumovita, a sweetened gum, containing small amounts of charcoal and iron phosphate having a winter-green flavor. Mecca Compound, an ointment containing carbolic acid, camphor, borates, zinc compound, sodium soap in a soft paraffin base. Best Cough Remedy, a spearmint syrup containing alcohol, chloroform and morphin. Stella-Vitæ, a female weakness remedy. Vegetable Pulmonary Balsam, a syrup flavored with spearmint, sassafras, containing alcohol and opium. (*Jour. A. M. A.*, Feb. 17, 1917, p. 565 to 566; Feb. 24, 1917, p. 651.)

**THE WILLARD PYORRHEA TREATMENT.**—After defrauding the public of amounts estimated by the federal investigators at \$75,000 a year by means of a fake cure of pyorrhea, F. W. Willard, M. D., D. D. S., has been denied the use of the United States mails. The business of the Willard concern, apparently owned by Oren Oneal, consisted of a mail-order plan of a so-called home treatment for pyorrhea or Riggs' disease. (*Jour. A. M. A.*, Feb. 10, 1917, p. 477.)

## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or P. O. Box 136, Jacksonville, Fla., U. S. A.

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**Next Meeting — Tampa — May, 1918**

## VOLUSIA COUNTY MEDICAL SOCIETY.

The Volusia County Medical Society has gone a long way in solving the problem dealing with the lack of interest in the average county organization. In a society of from ten to thirty members, the work can be made most interesting and highly profitable and fascinating by the adoption of the symposium method in dealing with subjects at each meeting. In preparing for these meetings the president selects the subject best adapted to each member for his part in the work and every man presents a written paper on a particular phase of the matter. If the member cannot be present, his paper is read by the secretary. Each member has some part aside from the rich discussion which follows in each meeting, and the discussion does not become involved in matters concerning other subjects as is often the case when no definite program is followed. These papers are short (usually five minutes), are terse and are supposed to contain "the meat" of the subject.

For the second time the present number of THE JOURNAL is given over largely to just one meeting of the society which was held in DeLand November 8th. The symposium was devoted to cystitis. A review of these articles will show the study beginning with the anatomy of the bladder and ending with the modern treatment of cystitis. The papers are rich in practical suggestions and show that the author of each paper has taken some time to look up his subject. It has been found that the study course suggested by the A. M. A. is not practical in small societies with towns twenty-five miles apart, and this method has proven after two years trial most valuable under conditions of this sort. Obstetrical subjects, fevers, senility, neurasthenia, the heart and almost any subject can be profitably studied in this way. Last year at Daytona and in Ormond your state secretary was present in two of these meetings and can strongly endorse the method. Members obliged to be absent express themselves as deploring their loss.

Occasionally a prominent man from the larger centers is invited to address the society and lead in the symposium with a slightly longer paper. This man is selected because he is a specialist on the subject to be discussed. Members suggest material for future work and there is no lack of it. We would strongly commend this method to all societies in the state, large or small, for a thorough trial, and we believe its general adoption outside the state would be most profitable.

R. J. W.

### EVERY DOCTOR IN THE MEDICAL RESERVE CORPS.

What an ideal situation it would be, if every doctor in the United States who is mentally, physically and morally fit, was in this Corps.

The time is coming, and in the immediate future, when the Medical Reserve Corps of the Army must be immensely augmented, and so as to enable the Surgeon General to have at his command for immediate assignment, as conditions demand, a sufficient number of trained medical officers, let us take the above thought seriously.

We all know, from past history, the conserving value of an efficient medical corps, and this means number, as well as training.

A statement made by one high in authority in the Surgeon General's office, "that our fighting forces would be disseminated by sickness and casualties in six months, were it not for an efficient army Medical Corps," clearly emphasizes the importance of every doctor in the United States, meeting the requirements above referred to, accepting a commission in the Medical Reserve Corps of the United States Army.

The struggle in which we are now engaged, and for which we are preparing to take such a prominent part, depends for its success as much upon the medical profession as it does upon our combatant forces, and while we do not know that any such intention as herein suggested is in the mind

of the Surgeon General, it would at least give him the necessary Corps of medical officers upon which to draw, and thus serve the best interests of our country, and the best interests of the medical officer serving.

### HAMSTRINGING THE ARMY.

The forces arrayed against scientific medicine are many and various. They range from the honest but deluded crank with an obsession through the various cults and 'pathies to the downright quacks and medical fakers. The American Medical Association as representative of scientific medicine in this country has, naturally enough, been the target for many of the verbal poison-gas attacks made by these different interests. In general, the Association and the profession have ignored such outbursts, for in many instances one of the obvious objects of the attackers has been to obtain, through a reply, a publicity they could never get through the avenues normally open to them. In this matter, as in many others, war brings about changed conditions. Vilifying scientific medicine in times of peace was a matter that affected chiefly only the physician, and he, knowing its source, ignored it. With the entry of our country into war, medicine, in common with other sciences, was called on to do its "bit" in successfully prosecuting the gigantic task the nation had undertaken. How well it has responded we will leave others to say. The facts are that the lives and health of the hundreds of thousands of young Americans who form the new National Army have been entrusted to the care of the representatives of scientific medicine.

During the past few months there has been an especially virulent effort on the part of the opponents of modern medical science to discredit that science in the eyes of the American public. Not only has it been openly charged that the physicians in the Army are incompetent to care for the health of the soldiers, but the villainous accusation has also been made that much of the sickness in the camps is the result of the prophylactic



inoculations given the men at the time they entrain. These charges, of course, emanate chiefly from ignoramuses of the "drugless healer" type. Such a campaign may be counted on not only to weaken the confidence of the American public in the medical department of the Army, but also to arouse unfounded suspicions in the very integrity of the military organization.

These thoughts are suggested by a recent article appearing in the *Los Angeles Times*. While the advertising pages of the *Times* are a notorious haven for quackery, the paper generally is supposed to have some influence. One of the departments of the Sunday editions of the *Times* is entitled "Care of the Body," and is conducted by one Brook who calls himself a "Doctor of Naturopathy." It would probably be difficult to put in the same space more misinformation regarding the human body and its processes than Brook manages to condense into his "department." The *Times* seems to have two obsessions, an undying hatred of labor unions and a deep-seated antipathy to the medical profession and medical science. This may explain why its alleged "health department" is turned over to a quack who also advertises his trade in the same paper.

In the *Times* for December 16, Brook suggests, both directly and by inference, that the cases of measles and pneumonia that have occurred in the various Army camps are "in part at least \* \* \* due to the fact that their [the soldiers'] blood has been poisoned with injections of diseased animal matter \* \* \* " In the same article Brook denies that medicine has progressed since the days of Hippocrates; he declares that "all disease has one cause, the accumulation of waste matter in the blood, due to surplus by-products of food"; that epidemics "occur when atmospheric conditions are favorable to them"; that "tertiary syphilis is mainly due to mercurial poisoning"; that physicians "of the regular school do not understand disease"; that pathogenic bacteria are never the cause, but always the result, of disease;

that "the percentage of deaths from diphtheria is as large as it ever was"; that the "increase in cancer is attributed by some medical men to the general use of serums"—and so on *ad nauseam*.

The article can have only a pernicious and disquieting effect, not alone on the soldiers themselves, but also on their families and friends. Had the *Times* falsely charged that our soldiers were being sent to fight Germany armed only with old-fashioned muskets or blunderbusses; or had it charged that the warships of the United States Navy are so obsolete and old-fashioned as to imperil the lives of our sailors, that paper would have played into the hands of our enemy no more effectively than it does when it spreads broadcast ignorant slanders regarding the efficiency of modern medical science and attempts to discredit the modern physician and challenge the value of the service rendered by the Army Medical Corps.

If modern medical science is a pretense and a sham, if inoculations against typhoid and smallpox are mere dangerous fads, if the health and lives of our brothers and sons who have been called to the colors are not in safe hands, then, in the name of common sense let us abolish the medical department of the Army and substitute instead a corps of chiropractors, naturopaths, mental healers and what-not in its place. If, on the other hand, the value and effectiveness of antityphoid inoculation and vaccination have been demonstrated and if everything is being done that modern science can do for the health of the Army, then those sheets that are attempting to disseminate falsehood to undermine the morale, not only of the Army, but of the public, and in other ways give aid and comfort to the enemy, should be promptly suppressed by the government.—*Jour. A. M. A.*, January 5, 1918.

IT IS NOT NECESSARY TO FORWARD YOUR APPLICATION BLANK FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY, TO THE SURGEON GENERAL. PRESENT IT, TOGETHER WITH THE OTHER PAPERS REQUIRED BY REGULATIONS, TO THE EXAMINING BOARD AT THE TIME YOU APPEAR FOR EXAMINATION.

APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.

Sir:

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....
4. When and where were you naturalized? (For applicants of alien birth only.).....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....
10. If either parent or brother or sister has died, state cause and age in each case:.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc.:.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates:.....
16. With what ancient or modern languages or branches of science are you acquainted?.....

\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.

17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result : \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine ; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.



## OUR HONOR ROLL.

Our Honor Roll as published below now constitutes a grand total of one hundred and forty-four physicians. They are divided in the services as follows: Medical Corps—Lieutenant Colonel, 1; Medical Reserve Corps—Majors, 6; Captains, 27; 1st Lieutenants, 96; total, 130. United States Navy—Passed Assistant Surgeons, 2; Assistant Surgeons, 3; total, 5. National Guard United States (Fla.)—Majors, 3; Captain, 1; 1st Lieutenants, 5; total, 9. The list is gradually becoming complete; we urge all to help us maintain it in a thorough manner.

## MEDICAL CORPS, U. S. ARMY.

*Home Address.*

Lieut.-Colonel Joseph Y. Porter.....Key West

## MEDICAL OFFICERS' RESERVE CORPS.

Major Frank E. Artaud.....Key West  
 Major John E. Boyd.....Jacksonville  
 Major Frederick G. Barfield.....Jacksonville  
 Major Chauncey L. Chase.....Fort Dade  
 Major Harry Peyton.....Jacksonville  
 Major Raymond C. Turck.....Jacksonville  
 Captain E. G. Birge.....Jacksonville  
 Captain H. O. Black.....Jacksonville  
 Captain Andrew R. Bond.....Tampa  
 Captain Stanley Erwin.....Jacksonville  
 Captain Albert H. Freeman.....Starke  
 Captain James B. Griffin.....St. Augustine  
 Captain J. Halton.....Sarasota  
 Captain Henry Hanson.....Jacksonville  
 Captain H. H. Harris.....Jacksonville  
 Captain Maurice E. Heck.....St. Augustine  
 Captain Graham E. Henson.....Jacksonville  
 Captain Frederick E. Jenkins.....Palatka  
 Captain Owen H. Kenan.....Palm Beach  
 Captain S. M. R. Kennedy.....Pensacola  
 Captain Frank R. Maura.....Ojus  
 Captain William W. Mills.....Miami  
 Captain William B. Moon.....Lakeland  
 Captain Frederick C. Moor.....Tallahassee  
 Captain John MacDiarmid.....DeLand  
 Captain John D. McRae.....Tampa  
 Captain D. W. McMillan.....Pensacola  
 Captain Thomas A. Neal.....Sanford  
 Captain James B. Parramore.....Jacksonville  
 Captain James D. Pasco.....Jacksonville  
 Captain J. Y. Porter, Jr.....Key West  
 Captain M. B. Swift.....Orlando  
 Captain Harry F. Watt.....Ocala  
 1st Lieut. A. E. Acker.....Jacksonville  
 1st Lieut. Daniel M. Adams.....Panama City  
 1st Lieut. Allen M. Ames.....Pensacola  
 1st Lieut. C. A. Andrews.....Tampa  
 1st Lieut. Harold M. Beardall.....Orlando  
 1st Lieut. Henry P. Bevis.....Arcadia  
 1st Lieut. James H. Bickerstaff.....Pensacola  
 1st Lieut. Everard Blackshear.....Citra  
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1st Lieut. B. A. Burks.....Titusville  
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 1st Lieut. Wallace P. Crigler.....Ocala  
 1st Lieut. T. G. Croft.....Jacksonville  
 1st Lieut. Clinton W. D'Alemberte.....Pensacola  
 1st Lieut. James S. Davidson.....Clearwater  
 1st Lieut. Kenneth McC. Davis.....Westbay  
 1st Lieut. Gaston Day.....Jacksonville  
 1st Lieut. L. B. Dickerson.....Clearwater  
 1st Lieut. George W. Dupree.....Blue Creek  
 1st Lieut. Lester J. Efrid.....Tampa  
 1st Lieut. William T. Elmore.....Gainesville  
 1st Lieut. Orin O. Feaster.....Mulberry  
 1st Lieut. Nedy L. Gachet.....Century  
 1st Lieut. Harry C. Galey.....Key West  
 1st Lieut. Julian Gammon.....Jacksonville  
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 1st Lieut. Hugh St. C. Geiger.....Kissimmee  
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 1st Lieut. O. F. Green.....Mayo  
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 1st Lieut. William J. Lancaster.....Tampa  
 1st Lieut. Richard Leffers.....Lakeland  
 1st Lieut. John P. Long.....Lake City  
 1st Lieut. John W. McClane.....St. Petersburg  
 1st Lieut. George S. McClellan.....Wellborn  
 1st Lieut. James R. McEachren.....Monticello  
 1st Lieut. Harry B. McEuen.....Quincy  
 1st Lieut. William G. McKay.....Jacksonville  
 1st Lieut. R. B. McLaws.....Tampa  
 1st Lieut. Earle H. McRae.....Tampa  
 1st Lieut. H. R. Mills.....Tampa  
 1st Lieut. George M. Mitchell.....Jacksonville  
 1st Lieut. Joseph A. Mixon.....Pensacola  
 1st Lieut. H. P. Newman.....Bartow  
 1st Lieut. John A. Newnham.....Cleremont  
 1st Lieut. John K. Norwood.....Jacksonville  
 1st Lieut. Bascom H. Palmer.....Tampa  
 1st Lieut. Henry E. Parnell.....Fort Myers  
 1st Lieut. Archie R. Parrott.....Jacksonville  
 1st Lieut. James L. Pennington.....Fountain  
 1st Lieut. J. O. Philips.....Worthington Springs  
 1st Lieut. William H. Pickett.....Gainesville  
 1st Lieut. Marion E. Quina.....Pensacola  
 1st Lieut. Shaler A. Richardson.....Jacksonville  
 1st Lieut. Dwight M. Rivers.....Lake City  
 1st Lieut. E. T. Sellers.....Jacksonville  
 1st Lieut. George W. Sherouse.....Campville

1st Lieut. E. E. Strickland .....	Miccosukie
1st Lieut. Baldwin S. Stutts .....	Port St. Joe
1st Lieut. G. C. Tillman .....	Gainesville
1st Lieut. W. J. Vinson .....	Tarpon Springs
1st Lieut. Adam C. Walkup .....	McIntosh
1st Lieut. Archie Watson .....	Live Oak
1st Lieut. B. L. Whitten .....	Fort Pierce
1st Lieut. John M. Whitfield .....	Malone
1st Lieut. William E. Whitlock.....	Fort White
1st Lieut. Charlton C. Whittle .....	Nocatee
1st Lieut. Daniel B. Williams .....	Lake City
1st Lieut. Albert H. Wilhienson.....	Jacksonville

THE NAVY.

Passed Assistant Surgeon W. P. Dey..	Jacksonville
Assistant Surgeon Thomas S. Field....	Jacksonville
Assistant Surgeon Boyd Gilbert.....	Pensacola
Passed Asst. Surgeon J. Knox Simpson,	Jacksonville
Assistant Surgeon D. C. Thompson.....	Pensacola

NATIONAL GUARD UNITED STATES (FLA.).

Major Lorin Green .....	Jacksonville
Major Ralph Green .....	Jacksonville
Major James H. Livingston .....	Jacksonville
Captain W. J. Buck .....	Gainesville
1st Lieut. Daniel C. Campbell.....	Marianna
1st Lieut. John R. Hawkins .....	Williston
1st Lieut. Z. V. Johnson .....	Milton
1st Lieut. Lucien B. Mitchell .....	Tampa
1st Lieut. J. M. Mitchell .....	Millville

TEN YEARS OF THE FOOD AND DRUGS ACT.

Ten years of enforcement of the Food and Drugs Act of June 30, 1906, are reviewed in the current annual report of the Bureau of Chemistry, United States Department of Agriculture, which says that the act's chief contributions to the safety of the people's health have been its corrective effect upon the drug and patent medicine industry, its control of trade in unclean milk, polluted, decomposed or filthy foods, and protection of foodstuffs from contamination with poisons likely to be met in manufacture.

The general effect of the Food and Drugs Act may best be estimated, says the report, by considering its effect upon food and drug control by the States; upon development of the food and drug industries and by the principal abuses that have been corrected. But to illustrate the scope of the work through figures and facts the report points out that more than 6,000 prosecutions have been terminated in the courts in the first decade of the Act; that manufacturers have been cited at hearings more than 40,000 times, that many thousands of factory inspec-

tions have been made, and that more than 750,000 shipments of domestic or imported food and drugs have been examined.

Special attention has been given to shipments of polluted or spoiled food. Milk shipped in interstate commerce and imported from Canada has been improved in cleanliness, purity, and the condition of sanitation under which produced. The canning of decomposed navy beans has been largely suppressed. Interstate shipment of oysters from polluted waters has practically ceased. Because of cooperation with State and municipal officials in controlling the shipment of bad eggs, it is reported that the quality of the eggs reaching the large cities is much improved. Other products in whose handling and sale improvement has been noted include mineral water, tomato products, fruit, vinegar and gelatin.

*States Cooperate with Federal Laws.*

One consequence of the enactment of the Food and Drugs Act was to encourage similar legislation in many of the States, the purpose of which is to control local traffic in food and drugs which, since no interstate commerce is involved, are not subject to the Federal law. For example, in 1906, many States had no feeding stuffs laws. A State could not prosecute a manufacturer unless he were a citizen of that State. The Federal law supplements the State law in this respect and now most of the States have similar laws.

In the beginning the confusion and apparent conflict between local and Federal laws and administration of laws not only made it difficult for the two sets of officials to cooperate, but often made it necessary for manufacturers to make special preparations for shipment to certain States at extra cost, the extra cost being passed on to the ultimate consumer. This evil has been remedied to a considerable extent by the organization of two agencies which, in large measure, have removed some of the difficulties arising from the conflict of Federal and State jurisdiction. These agencies are (1) The Joint Committee on Definitions and Standards and (2)

The Office of Cooperative State and Federal Food and Drug Control.

*Development in Food and Drug Industries.*

The Food and Drugs Act was one of the first laws which today would be classed as laws for the prevention of unfair competition. The report says that the suppression of fraud upon the consumer and of unfair competition among business rivals are "but the two faces of the same coin." In consequence the food industries are sincerely and actively helping the Bureau of Chemistry to enforce the law.

Frequently, the report says, the Bureau is appealed to by the industries to compel the cessation of unfair practices and to encourage the standardization of the products, when the industry is incapable by itself of bringing about these results. The Act is described as one of the influences which have helped to draw competitors together into association like the guilds of the middle ages, although the modern associations lack the special privileges which the ancient guilds often enjoyed.

Some of the associations, understanding the value of constructive work, now devote considerable money to experimental research into technical problems. Thus is made available to the small manufacturer scientific assistance ordinarily beyond his reach. Since the Bureau of Chemistry always has regarded it as its duty not merely to report violations of the law but also to prevent accidental violations, through constructive work in tending to improve methods of manufacture, it cooperates actively with such associations of manufacturers. Such cooperation, by the various Government agencies, says the report, is bound to exert the profoundest influence on the country's industrial and social development.

*Abuses Corrected by Law.*

The best evidence, according to the report, that many of the abuses formerly occurring in the food industry have ceased is found in the fact that the violations of the Food and Drugs Act observed today are hardly com-

parable, in degree, with those in the first few years following the enactment of the law.

Most of the staple-food products now found in violation either are of a higher grade than formerly or are products of clever adulterators who have more or less anticipated detection so that the adulterations have been found only by the most painstaking chemical analyses and factory inspection.

Consequently there has been a decided change in the direction of the work. In recent years it has developed quite noticeably in the direction of factory sanitation; of the study of spoilage and decomposition of foodstuffs and of improvement through laboratory research of methods of detecting the more refined types of adulteration.

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COMMON SODAWATER GLASS  
MUST GO THE WAY OF PUBLIC  
DRINKING CUP.

The public drinking cup was found guilty of causing so many epidemics that it was long ago abolished in nearly every State. But until recently little or nothing has been done to curb the dangerous tendencies of the sodawater glass, which has even greater possibilities for evil than the common cup. A soda glass may be used by many different persons, and the nature of the mixtures it contains makes it a much more favorable breeding place for germs than a cup used only for water, says the *New York American*.

An examination under the microscope of one carelessly washed sodawater glass revealed in the thick coating of filth which covered it both inside and outside more than 20,000 decaying human cells and bits of dead skin. Clinging to a single one of these cells there were counted 150 disease germs. The total germ population of the glass was estimated at 3,000,000, representing a dozen serious diseases.

Dr. Tanza, of the United States Public Health Service, believes that the dirty soda fountain has a great deal to answer for in connection with the spread of tuberculosis. He has frequently seen men and women in



the advanced stages of consumption drinking at soda fountains where no effort was made to cleanse the glasses and other utensils beyond a hurried rinsing in standing water.

Children are most seriously menaced by the dirty fountain because they are so fond of sodawater and ice cream and because their powers of resistance to disease are not yet well developed. Science is sure that there is no more certain way of exposing boys and girls to a wide variety of serious diseases than by letting them spend their nickels at soda fountains which fail to sterilize their glasses and take other sanitary precautions.

In the attempt to abolish the dirty soda fountain it is not sufficient to insist merely upon the equipment necessary to give sanitary service. The best equipped fountains are often the most unsanitary, on account of the indolence and ignorance of their employees. What seems to be needed are stringent regulations for safeguarding the health of patrons of soda fountains in every possible way, with severe penalties to the proprietors as well as to the clerks for neglect.

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### PATENT MEDICINE LABELS MUST SPEAK TRULY.

Ten years ago there was no ailment to which human flesh is heir that some maker of patent medicines did not claim to be able to cure with such ease that it seemed almost the height of foolishness not to part with the price for his nostrums.

Today, because of the operation of the Federal Food and Drugs Act, the extravagant promises of cure that characterized the labeling of the patent medicines of ten years ago have practically disappeared from the preparations that enter interstate commerce. They may, however, still be found in newspaper and other advertisements that are not subject to the act. The "pure food law," as it is known, is concerned only with the package as it is shipped in interstate commerce. If one questions the truth of a newspaper advertisement of a patent medicine, let him read

the label on the carton or bottle at the corner drug store. The latter will come nearer telling the truth about the medicine.

Misbrandings, in regard to healing value of hundreds of alleged cancer cures, so-called "cures" for coughs, colds, consumption, kidney diseases, epilepsy, St. Vitus dance, and the like, have been corrected. This is told in the annual report of the Bureau of Chemistry, United States Department of Agriculture, which reviews the operation of the Food and Drugs Act in the safeguarding of the health of the American people.

The law requires the labels of patent medicines to declare the presence of any habit-forming drug, such as opium, cocaine, or alcohol, thus preventing the innocent development of the drug habit. This provision of the law is particularly valuable in warning mothers against the use of so-called infant soothing syrups containing opium.

When the act went into effect, drug addiction was so prevalent that frauds in the treatment of the victims were frequent and in most instances the remedy advertised so forcefully by the labels contained the very drug from which escape was desired.

In 1907 the Bureau of Chemistry found that thirty soft drinks contained small amounts of cocaine. Practically all of these were suppressed. The Food and Drugs Act is regarded as having been an important factor in bringing about passage of the Harrison Anti-Narcotic law, which more effectively controls habit-forming narcotics.

Much has been done, the report says, to control the indiscriminate use of so-called headache remedies containing dangerous, depressing drugs, and of dangerous cosmetics making claim to healing value; and in raising the quality of the supply of crude drugs through the examination of imports. As a result of cooperative work with the Postoffice Department, a number of fraud orders were issued by the department preventing the use of the mails in promoting the sale of fraudulent medicines.

## TRADE COMMISSION ACTS ON SALVARSAN PATENT.

The Federal Trade Commission today entered orders for licenses to three firms to manufacture and sell the product heretofore known under the trade names of "Salvarsan," "606," "Arsenobenzol," "Arsaminol," patent rights which have been held by German subjects. The orders for licenses are subject to acceptance and agreement by the licensees to the stipulations made by the commission. Upon such acceptance and agreement, licenses Nos. 1, 2 and 3 will be formally granted by Secretary L. L. Bracken, acting for the commission.

Hereafter, this important drug will be manufactured and sold under the name of "Arsphenamine."

The Trade Commission's action was taken under Section 10 of the Trading With the Enemy Act, under direction of Commissioner Fort, upon recommendation of C. H. McDonald, Edward S. Rogers and Francis Phelps, in charge of granting such licenses. The Public Health Service has prepared rules and standards for the manufacture and testing of "Arsphenamine," and will supervise its manufacture, authority having been conferred on the Public Health Service by the Secretary of the Treasury, and the observance of the rules and standards become a condition of the license.

The three firms which will be hereby permitted to manufacture and sell "Arsphenamine" are Dermatological Research Laboratories, of Philadelphia; Takamine Laboratory, Inc., of New York, and Farbwerke Hoechst Company (Herman A. Metz Laboratory), of New York. The original patent for manufacture of what has heretofore been known as "Salvarsan," etc., was issued to Paul Ehrlich and Alfred Berthelm, German subjects, and assigned to Farbwerke Vormal's Meister, Lucius and Druning of Hoechst on the Main, Germany.

The supply of the drug now licensed to be made in America, up to 1915, was almost exclusively obtained by importation from

Germany. It is at present the only known specific for virulent blood poison. From the outbreak of the war importation became more difficult.

Before the war began, the patented drug was sold at \$4.00 per dose, which is approximately \$3.500 per pound, and speculatively it has brought as high as \$35.00 per dose. While the price of the product is not fixed at this time by the commission, the right to fix prices is retained, and a price of \$1.00 per dose to the Army and Navy, \$1.25 per dose for hospitals, and \$1.50 per dose for physicians, are the prices at which some, at least, of the licensees have stated that they intend to offer the licensed drug.

The enormous shortage of supply on this important product will immediately be relieved, and the article placed in the hands of the Government, the hospitals and the medical profession at a price lower than ever before.

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## DEATH CERTIFICATES.

More accurate and definite statements of the occupations of decedents should be written upon death certificates. Until this is done mortality statistics by occupations will continue to be unsatisfactory.

The Bureau of the Census is planning for the near future a monograph on tuberculosis. How much more valuable this monograph will be if it is possible to show accurately the occupations of decedents.

As a physician you appreciate the importance of such statistics. As a physician you are by education better qualified than the ordinary informant to understand a proper statement of occupation.

Will you not, therefore, take pains to see that the occupation items upon each one of your death certificates are properly supplied?

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America will deserve to lose this war if, through unwillingness to practice small economies, it fails to save the food necessary to keep our allies in the fight until victory is won.

## Cancer Department

*"In the early treatment of cancer lies the hope of cure"*

AMERICAN SOCIETY FOR THE CONTROL OF CANCER

### MAGAZINE COOPERATION.

Through the cooperation of Mr. Dudley Harmon, Manager of the Washington Bureau of the *Ladies' Home Journal*, the following paragraph on the work of the Cancer Society was published on the "Keeping Up With the Times" page of the May issue of the magazine:

#### "THE TRUTH ABOUT CANCER."

"There are some people in this country who have made it their task to give the public the facts about cancer, its symptoms, treatment and cure. They have formed the American Society for the Control of Cancer, at 25 West Forty-fifth Street, New York, which is supported by most eminent men of science and the medical profession. The Society does not give medical advice or treatment, but it will help anyone to know about one of the greatest scourges of mankind and how it may be combated."

About seven hundred inquiries for information and advice, which are directly traceable to this small insertion, have been received at the headquarters office of the Society and even now, after the lapse of many months since the publication of the paragraph, occasional inquiries are received from small towns and villages where the old number of the *Journal* is still being read.

The requests for information represent all parts of the country and illustrate very forcibly the need of the campaign for cancer education. They come from physicians, nurses, and social workers who want the literature and instruction for use in connection with their work and from patients, or those fearing cancer for themselves, their friends or families. One woman, writing for advice regarding the recognition of the warning signs of the disease, adds: "I surely

want to know in time, and not wait too late as did my sister." And another, telling of her care of her mother who had recently died of cancer, writes "I wish, with all my heart, to know enough so that no other member of my family need die of cancer through any ignorance on the subject."

Appreciating the remarkable interest aroused by this bid for correspondence made through the *Journal*, the Society has recently sought the cooperation of other women's magazines of large circulation, and in this effort has met with the most welcome promises of help. An article has lately been accepted for early publication by the *Woman's Home Companion*. Another has just been prepared and submitted, upon invitation, to the *Woman's Magazine*. *The Designer*, contemplating a new series of health articles, has indicated its willingness to include an early paper on cancer, and the Society has been assured that *McCall's Magazine* will provide instruction on this topic in the health department it plans to install shortly in its publication.

In addition to this, Dr. C. E. Terry, Health Editor of *The Delinicator*, is considering the idea of running a series of articles dealing with the various phases of the cancer problem in subsequent numbers of that magazine. This method of presenting the subject in a lay periodical has not been employed heretofore, and the educational results of such a series, if conducted, will be followed with much interest.

Carefully prepared articles, designed to invite correspondence with the Cancer Society, afford a very unusual opportunity for our organization to serve the individual, and it is with a due appreciation of the value of the cooperation on the part of the magazines that this acknowledgment is made.



## PUBLIC HEALTH NURSING.

The following letter is self-explanatory and is published for the benefit of all interested. It appears to *THE JOURNAL* that the points brought out in this letter are well taken, and that the matter is one which should receive the serious consideration of the profession:

THE NATIONAL ORGANIZATION FOR  
PUBLIC HEALTH NURSING,  
600 Lexington Avenue,  
New York.

October 20, 1917.

Dr. Graham E. Henson, Secretary,  
Florida Medical Association,  
Jacksonville, Fla.

DEAR DR. HENSON—Public health nurses have greatly increased during the past few years. Hundreds, perhaps thousands of small towns and rural communities as well as large cities have come to regard them as indispensable community servants. Their service represents at least a minimum of skilled nursing which can usually be supplemented with safety by family, neighbors or trained attendants. They also stand as much for the protection of health as for the care of the sick. Their value as health agents is now pretty generally recognized by health officers, school boards, and manufacturers as well as by the public itself.

Because their work is largely preventive, one of their chief values is that they persuade many people to call upon their doctor before an illness has become serious enough to have convinced them that it was necessary to consult him. Nevertheless, their opportunities as health teachers most often depend upon and follow their entrée to the homes in time of need due to illness. They are very dependent upon the local physicians because it is an invariable rule that no visiting or public health nurse shall perform any treatment nor administer any medicine, nor even make repeated calls upon a patient except with the consent and direction of the family physician.

Oftentimes these facts are not understood by country doctors and consequently they refuse to call for the nurses' assistance and even discourage their patients and their families from doing so. This situation is becoming less and less frequent but still exists in some localities and among some doctors.

More than ever, these nurses will be needed now that so many physicians are being called to military duty and yet they can not serve the people unless the doctors who remain at home will recognize and call upon them.

The members of the National Organization for Public Health Nursing, among whom are many Red Cross Town and Country Nurses, have instructed me to bring this matter to the attention of the State Medical Associations in the hope that they will see fit to urge their county societies to interpret the work of public health nurses to their members to clear away the misunderstandings which are now in some places preventing the best and fullest use of public health nurses and to encourage employment of their services.

Representative women in this field will welcome opportunities to discuss the subjects before state or local associations.

Sincerely yours,

ELLA PHILLIPS CRANDALL,

*Executive Secretary.*

## CHILDREN IN WAR-TIME.

War work for babies which resulted in lowering the infant death rate in Great Britain, France, Belgium, and Germany is described by Dr. Grace L. Meigs of the Children's Bureau of the U. S. Department of Labor in a paper on Infant Welfare Work in War-Time which the bureau has just made available for general distribution.

The special features of the work have varied in the different countries. In England there has been a striking increase in the number of health visitors employed to help and to instruct mothers in the care of

their babies and young children. An act providing for Government aid to local agencies had, as it happened, been passed in July, 1914:

"The Local Government Board (the central supervising and administrative body) has taken the stand that in war-time, in spite of the general need for economy, no economy should be exercised in this direction. There is evidence that in a good many communities, on account of lack of money and private support, the authorities or voluntary agencies have been slow to increase their work or to undertake new work. These difficulties the Local Government Board has largely overcome. It has gone on with the greatest determination towards its acknowledged goal—to have systematic supervision through the work of health visitors for all babies born who need care."

The available information for Germany concerns only the first eighteen months of the war. Dr. Meigs refers to the emphasis placed on enabling mothers to care for their own children. A special committee of the Red Cross, for example, was organized in Berlin for the care of mothers and infants. The committee had a fund for needy mothers which it used for those mothers who brought their babies regularly to an infant-welfare station and who took care of them in their own homes.

The outstanding feature of the work in Paris seems to be the increased provision for maternity care; and in Belgium, the establishment of canteens for the feeding of mothers and of young children.

Dr. Meigs speaks of the important part played by the military separation allowances which are granted by foreign Governments to the wives of enlisted men, either, as in Great Britain and Canada, to the wives of all soldiers or, as in France and Germany, to the wives who are in need because the family's wage earner has been called to the colors.

Furthermore, in each of these countries except Belgium a maternity benefit from

Government funds, provided before the war to certain mothers, has now been extended to include either the wives of all enlisted men or all women who are receiving the military separation allowance.

Dr. Meigs bases on the experience of these countries the following practical war-time suggestions for the United States:

The chief preventive measure for protecting babies is to insure their intelligent care and nursing by healthy mothers in their own homes.

Nothing should be considered more important in war-time than the strengthening and extending of preventive work already established for infant and maternal welfare. The disorganization of such work through the loss of physicians and nurses especially trained for it should be avoided if possible.

Every effort should be made to enlist a large number of candidates for hospital training courses.

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#### HOME-CANNED FOOD SAFE.

##### *No Need to Fear Botulism in Properly Prepared Products.*

The United States Department of Agriculture today issued the following statement prepared by the bacteriologists of its Bureau of Chemistry and the States Relations Service:

"There is no danger that the type of food poisoning known as 'Botulism' will result from eating fruits or vegetables which have been canned by any of the methods recommended by the United States Department of Agriculture, provided such directions have been followed carefully. It is possible that in a number of instances the directions were not strictly followed and that spoilage has occurred. Of course, extreme care should be taken to ascertain before eating canned goods of any kind whether they are in good condition, and if they have spoiled, they should not be consumed.

"In case of any doubt as to whether the contents of a particular can have spoiled, the safest plan is to throw it away, although all

danger of Botulism may be avoided by boiling the contents of the can for a few minutes, since the *Bacillus botulinus* and the toxin or poison which it produces are killed by such treatment. No canned food of any kind which shows any signs of spoilage should ever be eaten. In the cold pack method of canning given out by the Department of Agriculture, only fresh vegetables are recommended for canning and sterilization is accomplished by the following processes: cleansing, blanching, cold dipping, packing in clean, hot jars, adding boiling water, sealing immediately, and then sterilizing the sealed jars at a minimum temperature of 212 degrees Fahrenheit for one to four hours, according to the character of the material. Since the spores of *B. botulinus* are killed by heating for one hour at 175 degrees Fahrenheit (according to Jordan's "Bacteriology" and other recognized textbooks), there is no reason to believe that the *botulinus* organism will survive such treatment."

### THE INCREASING MENACE OF LOBAR PNEUMONIA.

#### *Insurance Statistics Show Marked Rise in the Death Rate.*

Lobar Pneumonia today causes more deaths than any of the other acute infectious diseases. This is clearly shown in a report recently prepared by the Metropolitan Life Insurance Company on its mortality experience covering the last six years. During this period there occurred nearly thirty-eight thousand deaths from lobar pneumonia among the Industrial policyholders of this company.

#### *Pneumonia Death Rate Increasing.*

The death rate from lobar pneumonia is not showing improvement from year to year as is the case with most of the other infectious diseases. The year 1916 was an especially bad one for this disease, the rate having increased very perceptibly over the preceding four years. The very severe grippé

epidemic which prevailed in 1916 may have had some bearing upon this result.

#### *Pneumonia More Prevalent Among Colored Than Among White Persons—Mortality Higher Among Males Than Among Females.*

Although prevalent at the early ages, lobar pneumonia is not essentially a disease of early childhood. When it does occur in young children, it is very frequently fatal. The disease reaps its greatest harvest at the ages over 65. At these ages it is one of the chief causes of death. The insurance figures, furthermore, show that the colored people have a much higher mortality rate than is found for the whites. This is true for both sexes and for every period of age. Pneumonia has a higher death rate for the male sex than for the female.

#### *Cases of Pneumonia Should Be Reported and Quarantined.*

In view of these facts it is clear that a vigorous public health campaign must be directed by communities against the ravages of lobar pneumonia. Some health departments have already taken a forward step in declaring lobar pneumonia a reportable disease, like measles and scarlet fever, requiring visitation by the health departments to insure quarantine. This is a new idea for most people. There are, undoubtedly, millions of persons in the country who would not go into a house where there was measles, scarlet fever, whooping-cough or diphtheria, but who would not hesitate to go into a sick room where there was a case of acute lobar pneumonia. Nevertheless, the best medical authorities have shown that this disease is extremely infectious, and that those who are stricken with it have a worse chance of recovering than if they had any of the infectious diseases mentioned.

More states and cities should require that physicians report every case of lobar pneumonia and must enforce this requirement. Communities can also help by checking the nasty habit of spitting in public places, which



is probably the most fruitful method of spreading the germ of pneumonia.

The form of pneumonia known as broncho-pneumonia is also a serious factor in the death rate, especially of young children; but must not be confused with the infectious disease which health departments are now taking steps to quarantine.

### BIG INCREASE IN NUMBER KILLED BY AUTOMOBILES.

#### *Insurance Study Shows Increasing Menace of the Automobile. Children the Main Victims.*

The startling fact that the death rate from automobile accidents has more than tripled since 1911 is disclosed by a study of the deaths among the Industrial policy-holders of the Metropolitan Life Insurance Company. In 1911 the death rate from this cause was 2.3 per 100,000; in 1916 it had increased to 7.4. During this period the rate for each year was markedly higher than the rate for the year before, and that for 1916 showed an increase of more than 37 per cent over the figure for 1915.

#### *Nearly One-third of Those Killed Are Children Under Ten Years of Age.*

The steadily climbing death rate from automobile accidents among the families of the country's wage-earners is due, very largely, to fatalities among little children. This investigation has developed the fact that of the 2,507 policy-holders who were killed by automobiles during the six years, 1911-1916, no less than 790, or about 32 per cent, were children under ten years of age, and 1,125, or over 44 per cent, were children under fifteen years of age. Unless something is done to check automobile fatalities, the time is approaching when the automobile as an instrument of death among children will become as serious and dreaded a factor as some of the deadly epidemic diseases upon which the attention of health authorities has long been centered. There has been in recent years a marked decrease

in the death rate from such diseases as measles, scarlet fever, whooping-cough and diphtheria, but the rate for automobile accidents (surely as preventable a cause of death as any of these) is increasing by leaps and bounds.

#### *Mortality Caused by Automobiles and by Other Vehicles Compared.*

Another condition developed by this study is the fact that as far as the industrial subway trains, elevated trains, bicycles and horse-drawn vehicles combined. Indeed, in 1916 the 756 deaths caused by automobiles approaches very closely the 799 persons insured in the company killed on steam railroads.

The figures for Metropolitan policy-holders, it must be borne in mind, represent, almost exclusively, pedestrians, rather than those who ride in the machines. This is particularly true of the children. A large part of this mortality, it is evident, is due to reckless driving and to the heedlessness of children to the dangers to which they expose themselves. But whatever be the cause, it is clear from these figures that the automobile is an important agency of death and that its control by the communities must be immediate and thorough if improvement is to be made.

### SUICIDE MORTALITY AMONG WAGE EARNERS IN THE UNITED STATES.

#### *Insurance Figures Show Marked Improvement During 1916.*

The Metropolitan Life Insurance Company has recently completed a study of suicide as a cause of death among the industrial policy-holders of the company. According to this study, there has been a marked decrease in the death rate from suicide during the last few years. Among four million insured white males the number of suicides in 1916 was 620, or 15.3 per 100,000. In 1915, the rate was 19.6 per 100,000. The most frequent form of suicide among these

white males was by firearms (31%). Among nearly five million white female policy-holders, there were 308 suicides in 1916, or 6.3 deaths per 100,000 insured. In 1915 the rate was 7.5 per 100,000. Poisoning was the most usual method of suicide among the white females—more than one-third having been so accomplished.

*Negroes Show Lower Suicide Rates Than White Persons.*

The death rate from suicide among negro males is a little over one-half as high as among white. In 1916 the rate was 8.2 per 100,000 insured. Negro females show the very lowest rates of any of the groups studied. The rate was 3.4 per 100,000 in 1916, the total number of suicides being only 22 among over 650,000 insured colored women.

*Suicide More Prevalent Among Men Than Women.*

The figures show that suicide is more than twice as frequent as a cause of death among males than among females. This is true at all periods of life except at the ages 15 to 19. It is remarkable that the change from youth to adult life should disturb the mental life of females so much more than that of males. The same conditions are found to prevail among the white and the colored races. After early adolescence, the white female suicide rate remains practically stationary, never varying very much from about 11 per 100,000. On the other hand, the white male suicide rate increases with each age period. The rate is highest at the ages 65 to 74, when it is over 80 per 100,000. Suicide is then a very common cause of death, nearly five times as prevalent as at the age period 20 to 24.

*Suicide Among Wage Earners and the General Population Compared.*

Among both white male and female policy-holders of the company, under 25 years of age, the suicide death rates are lower than those recorded among males and females in the general population of the Registration

Area of the United States. For each age period after 25, the suicide rate of insured males is slightly higher than for the male population at large. White females insured in the company, however, show a lower rate than females in the general population throughout life.

If the suicide rate is an indication of the mental health of the people, it would appear from these figures that the housewives of the industrial families of the country are the best balanced of all. Their husbands are not quite so well favored.

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WAR PRICES DEPRIVING BABIES OF MILK.

Decreases reported from New York and Chicago and New England cities in the amount of milk now being consumed by families with young children have led the Federal Children's Bureau to emphasize its imperative necessity in the diet of babies and young children.

Dr. Grace L. Meigs, the Director of the Bureau's Child Hygiene Division, in commenting on the danger of such a decrease to the health of children today, said, "Milk is the one food that all young children must have if they are to be strong and healthy. Whole milk is rich in the elements without which the child's growth ceases and his health is impaired; indeed there is no food which can supply as well the needs of the growing child.

"There is no substitute for milk in the diet of babies and young children. Yet the increase in its price is so startling that, as the reports the Bureau receives show, many mothers are economizing on milk. Young children can not get the nourishment they require from the would-be milk substitutes given them. Patent foods which do not themselves contain milk and are not intended to be mixed with milk are so lacking in the essentials of healthy development that we must expect children fed on them instead of on milk to be weakly and ailing. Plainly very great harm is done young children by

giving them tea and coffee to take the place of milk which is really a complete food; it is giving them mere stimulants to replace their best food."

Since the price of milk went up to 14 cents a quart, tea and coffee have been substituted for milk by more than half of the 2,200 families — all with children under six — included in the study of the effect of the increased price of milk just made in New York City by the Mayor's Committee on Milk, the City Department of Health and the Association for improving the Condition of the Poor. One hundred and twenty families have stopped taking milk entirely, in 25 of these there are babies under one year old. All the 2,200 families have young children, but nearly half are taking from one-fourth to one-half less milk than before the price went up. Yet even before the larger price decreased the amount of milk they bought these families were getting but little more than half the amount of milk which experts on children's diets say they need.

In Chicago as well as New York the rise in the price of milk has forced down the amount purchased. A dealer there reports that while he distributed on an average 4,000 quarts of milk a day in September, on October 3 with the price increased, he distributed only 2,500 quarts.

In New Haven, Bridgeport and other Connecticut towns milk delivered at the station is sold wholesale at 8 cents a quart. It retails as high as 15 cents a quart. In Waterbury, when the price was raised from 12 to 15 cents a quart the sale was so greatly reduced that the price has been dropped back to 14 cents.

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### THE AMERICAN REVIEW OF TUBERCULOSIS.

Within nine months the *American Review of Tuberculosis* has made for itself a unique place in medical circles throughout the United States and in almost all parts of the world. Few specialized journals have received a more cordial welcome than this one has, as evidenced by its rapidly increasing

subscription list. The large number of medical men who are interested in the treatment and prevention of tuberculosis gives the Review an unusually extensive field.

The *American Review of Tuberculosis*, however, has an appeal also to those who are not directly interested in this disease, that is to the internists, to the laboratory men, and even to the surgeons who are specializing in related fields. Tuberculosis has many ramifications and is so intimately bound up with the practice of all physicians that this journal should find a ready place in the library of every man who wishes to keep himself posted for his own best interests and those of his patients.

The *Review* aims to be not only a clearing house for the best American thought and production in relation to the clinical, pathological and sociological phases of tuberculosis, but it aims at the same time to stimulate renewed interest on the part of those who are already working in this field and to arouse interest on the part of the general practitioners to whom tuberculosis does not make a very ready appeal. It is not a propaganda journal, but it does frankly aim to be educational, as every good medical journal should do.

Its editorial staff, headed by so well-known an authority as Dr. Edward R. Baldwin, of Saranac Lake, for so long an associate of Dr. Trudeau, and containing the names of men of such national and international prominence as Dr. Lawrason Brown, Saranac Lake, N. Y.; Dr. H. R. M. Landis, Philadelphia, Pa.; Dr. Paul Lewis, Philadelphia, Pa.; Dr. M. J. Rosenau, Boston, Mass.; Dr. Henry Sewall, Denver, Colo.; Dr. B. S. Veeder, St. Louis, Mo., and Dr. Allen K. Krause, Baltimore, Md., assures those who subscribe to this publication an unusually high grade of material. The further fact that the journal is published by the National Association for the Study and Prevention of Tuberculosis vouches for its standing and gives added assurance to its future.



The backing of the National Association for the Study and Prevention of Tuberculosis also makes it possible for the publishers to furnish the *Review* at so moderate a price as \$3.00 which, to those who know anything about the cost of production of such publications, will readily appear as less than the cost of production. We are glad to recommend the *American Review of Tuberculosis* to our readers and urge them to add it to their subscription lists. Subscriptions should be sent to the New York office at 105 East 22d Street, New York City.

### FAMINE, PRUSSIA'S ALLY.

Seven years ago a famous European student of history prophesied that the next great war would be won, not by fighting, but by famine. We are today fighting that war—and famine is hovering.

The men of England, Scotland, Ireland, France, Italy, Belgium—our allies—are fighting; they are not on the farms. The yield of their land is therefore cut down. Always they had to import much that they ate, drawing the shortage from many other countries as well as from America. Now that their shortage is worse than ever, there is little or none to be had from these other sources. They must be fed from America. Our allies, therefore, depend on us for food as never before and they ask for it with a right they never had before. For today they are doing the fighting, the suffering and the dying—in our war.

We *must* send them the food for their necessities. We *will* send it. But we can do it only by a wise and loyal economy of food on the part of every one of us. We must stimulate our food production, organize our food handling, eliminate all waste, use largely other foodstuffs for wheat, beef, pork, dairy products and sugar, and reduce consumption wherever it is in excess.

To gain these results is the task of the United States Food Administration. It can be done only by joining in one effort the willing service of all the people in the land.

To that end, every man, woman and child is asked to be a member of the Food Administration. No fees, nor dues—just a promise to help. The week of October 28 will be devoted to the nation-wide enrollment of all earnestly loyal Americans in the movement to win the war by making sure that our allies are not weakened and defeated by lack of food.

### WHOLESOMENESS AND ECONOMY.

The nation is at war. To protect our rights we must have an efficient fighting machine. The men must be given wholesome and nutritious food in sufficient quantity. The stupendous character of the conflict necessitates rigid economy of both men and material. Nothing is economy that renders food less wholesome, but there is no excuse for catering to prejudice at an increased cost. We shall need all our dollars before this war is over. We must secure for our soldiers the most wholesome food at the least cost.

Our governmental departments are subject to criticism by the whole country and it would not be surprising if they catered to known prejudices in order to avoid annoying criticism. But in time of war we must be governed by scientific facts and not by prejudice. Big interests whose advantage lies in the support of a prejudice may criticize, but our leaders must be big enough to practice economy in spite of such unjust criticism. That economy will be practiced and that scientific facts and not prejudice will guide the Government in the selection of wholesome foods is clearly indicated by recent actions by the Department of the Interior, the Army, and the Navy. All these departments have recognized the findings of the Referee Board of Scientific Experts who found that alum baking powders were as healthful as any other baking powders. These departments have recently purchased large quantities of alum phosphate baking powders. This is the type which was furnished our soldiers on the Mexican

border and subsequently to our sailors, and which proved so satisfactory. The people of the United States have recognized the wholesomeness and economy of this type of baking powder for years. Eighty per cent of the baking powder used in the United States contains alum. Its wholesomeness is unquestioned. Its economy is marked. Not only are alum powders generally much stronger, so strong that the manufacturers recommend the use of only half the quantity

called for by high-priced baking powders, but the price of the powder pound for pound is but half as much. This means that the use of one pound of phosphate alum powder at 25 cents does the work of two pounds of the other powders costing one dollar. The saving is 75 cents. War prices would have no terrors if we could make an equal saving on all our foods by substituting something equally wholesome, twice as effective and at half the price.

## Reviews from Current Literature

### OSTEOCHRONDITIS

Blanchard, Wallace: Treated and Untreated Osteochondritis Juvenilis of the Hip. *Jour. A. M. A.*, Vol. LXIX, No. 13, p. 1060.

"Perthes' disease, or osteochondritis juvenilis of the hip, results in far more extensive bone atrophy than has been supposed. The bone atrophy and rarefaction are so extensive that they have changed our previous conception of the pathology of the disease.

"Up to the present time, the only joint and bone changes recognized in Perthes' disease have been a partial or total destruction of the head of the femur with a stumping of the neck, together with a thinning of the femoral shaft. Most authors have agreed with the unsustained suggestion, made by Freiburg at the last session of the association, that the disease is caused by tonsillitis or some other local infection. Experiments have been made on animals by Allison to determine what influence a slight injury or displacement to the epiphysis might have on the hip, and his results were negative."

The whole pelvis, when studied on the side involved shows atrophic changes. If untreated, it goes on to marked erosion on the femur and permanent deformity.

"The author has been unable to find in any of his cases a tonsillar or other infection."

The disease is chiefly confused with tuberculosis of the hip and its chief dif-

ference is its ready response to treatment and many cases of cured tubercular hips were actually that of Perthes' disease.

His conclusions:

"1. Osteochondritis deformans juvenilis seems to be a nutritional disease of the bones and muscles of the hip and leg.

"2. The femoral head that continues in functional use during the acute stage of the disease becomes obliterated wholly or in part by the attrition of the weight bearing on softened bone.

"3. The head of the femur that is mechanically protected throughout the acute stage of the disease suffers only the same atrophic changes of the adjacent bones.

"4. In convalescence, the destroyed head redevelops rapidly under mechanical protection, and redevelops more slowly and less perfectly without protection.

"5. The disease progresses with one year of bone and muscle atrophy and lessened density, followed by several years of increasing density and redevelopment.

"6. The bone hardening resembles the eburnation after rickets.

"7. From the foregoing facts it may be inferred that this disease of growing bone is nutritional in character, and is due to a blood circulation that is disturbed from a median pelvic line to the foot, and that the head and neck of the femur are only incidentally affected.

"3. The question of etiology remains of chief interest."

L. W. C.

# THE WASSERMANN TEST

Smith, J. Wheeler, Jr., and MacNeal, W. J.: Comparative Study of Different Antigens and of Different Temperatures of Incubation in the Wassermann Test. *The Journal of Infectious Diseases*, Vol. XXI, September, 1917, p. 233.

The authors present the results of the examination of 501 specimens from 457 patients, using for each three different antigens and two temperatures.

The antigens used were cholesterol reinforced, simple alcoholic extract of beef heart and an acetone insoluble fraction of beef heart. The temperatures were 37 degrees C. for 30 minutes and 8 degrees C. for four hours to fix the complement.

The series was divided into groups of patients as follows:

Group I—Syphilitic .....	80
Group IIa—Evidently syphilitic .....	24
Group IIb—Probably syphilitic .....	20
Group IIc—Probably not syphilitic .....	16
Group III—Non-syphilitic .....	317
	457

The percentage of positive findings from the 124 patients certainly or probably syphilitic, groups I, IIa and IIb, follows:

Cholesterinized at 37 degrees C.....	65.3
Simple at 37 degrees C.....	37.5
Acetone Insoluble at 37 degrees C.....	46.5
Cholesterinized at 8 degrees C.....	83.3
Simple at 8 degrees C.....	73.6
Acetone insoluble at 8 degrees C.....	60.4

The percentage of negative findings of the 333 non-syphilitic patients, groups IIc and III, were:

Cholesterinized at 37 degrees C.....	97.
Simple at 37 degrees C.....	100.
Acetone insoluble at 37 degrees C.....	100.
Cholesterinized at 8 degrees C.....	97.8
Simple at 8 degrees C.....	100.
Acetone insoluble at 8 degrees C.....	100.

The whole article is so well summed up in their conclusions that they are given in full:

"1. The use of the cholesterinized antigen, with the first incubation, at 8 C., for 4 hours, constitutes a more sensitive test for syphilis than does any of the other methods examined.

"2. The cholesterinized antigen, both at 37 C. and at 8 C. is apt to yield nonspecific complement-fixation. Therefore, in a diagnostic reaction, fixation with the cholesterinized antigen alone is, at best, of only doubtful significance.

"3. The simple extract antigen, with the first incubation at 8 C. is more sensitive than the cholesterinized antigen at 37 C. and in this series it did not give any false positive reactions, according to the available evidence.

"4. The acetone insoluble preparation, made according to the method of Noguchi, is less sensitive, either at 37 C. or at 8 C. than is the cholesterol-reinforced antigen at either temperature, and is also less sensitive than the simple extract at 8 C. It is more sensitive than the simple extract at 37 C. and, in this series, has, according to the available evidence, given no false positive reactions."

B. L. A.

"NOSTRUMS FOR KIDNEY DISEASE AND DIABETES."—Prepared and issued by The Propaganda Department of *The Journal of the American Medical Association*. 47 pages; deals with 34 nostrums; illustrated. American Medical Association, 535 North Dearborn St., Chicago. Paper, 10 cents postpaid.

This is the latest pamphlet issued by The Propaganda Department of *The Journal of the American Medical Association* as part of its work in giving the medical profession and the public the facts regarding different phases of the nostrum evil and quackery. Nostrums for kidney disease and diabetes are grouped together in one pamphlet, not because there is any essential relation between diabetes and kidney disease, but because the average quack makes no distinction between the two conditions and recommends his nostrum indiscriminately for both. It is not necessary to tell physicians that drugs will not cure either kidney disease or diabetes but it is necessary to apprise the public of this fact. Whatever justification there may be for the sale of home remedies for self-treatment, there is no excuse, either moral or economic, for selling preparations recommended for the self-treatment of such serious conditions as



diabetes and kidney disease. Every "patent medicine" sold for the cure of these diseases is potentially dangerous and inherently vicious. The pamphlet is an interesting and instructive one to put in the hands of the layman.

### NEW AND NONOFFICIAL REMEDIES.

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practically non-toxic, even intravenously. Thorium salts are fairly radioactive.

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**THORIUM SOLUTION FOR PYELOGRAPHY.**—H. W. and D., 10 per cent.—It is the same as thorium citrate solution. Prepared by Hynson, Westcott & Dunning, Baltimore, Md.

## Publisher's Notes

### WORK WITH HOOVER AND SERVE OAT FOODS.

*"Wheatless Meal" a Patriotic Duty—Oats High in Energy Value and Low in Price.*

To sustain our Allies and our own army abroad, it is necessary for this country to ship to Europe 200,000,000 bushels of wheat the coming year, in place of a normal shipment of 80,000,000 bushels. That is why Herbert Hoover says we must eliminate waste of bread and must have one "Wheatless meal" each day. It is impossible to view this matter as other than a patriotic duty.

Yet the domestic housewife must look to the matter of serving nourishing meals.

An excellent food to consider as a flavory, nutritious, and easily prepared substitute for bread is oats, either in the form of oatmeal or oatmeal biscuits. As a food that imparts vim, energy, and endurance, oats have long been recognized as supreme. And in the form in which they can in these days be procured for table use, they excel nearly every other grain food in flavor and ease of preparation.

Again, oats have advanced little in price,

whereas nearly all other foods have soared. Prices on Quaker Oats—the product of the Quaker Oats Company of Chicago—for example, have advanced, on the smaller package only, from 10 cents to 12 cents, and on the large, only from 25 cents to 30 cents. Most other foods, for the same nutrition cost from twice to ten times as much. Even so simple a diet as bread and milk, for the same nutrition, today costs twice as much as oatmeal. The average mixed diet costs four times as much.

It has been estimated by food experts that oats, to the extent that they are used in place of other foods, on the table, represent a lower cost by 15 per cent, on the average, than what they take the place of.

A few specific comparisons may be interesting to the reader:

Per unit of nutrition, bacon and eggs cost five times as much as oatmeal; steak and potatoes cost five times as much; chicken costs six times as much, the average mixed diet four times as much.

In view of the critical food situation and the comparatively low cost of this superior food, the housewife, it appears, would do well to serve oats more often.

During Infancy and Childhood it is important but difficult to keep the bowels in order. It can be done by the continued use of

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♦ ♦ ♦

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# THE JOURNAL

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# Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV  
No. 8

St. Augustine and Jacksonville, Fla., February, 1918

Yearly Subscription, \$1.50  
Single Copy, 15c.

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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at St. Augustine, Fla., Oct. 23, 1914

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, February, 1918

Number 8

## ORIGINAL ARTICLES

### FLORIDA'S CARE FOR THE INSANE.

W. M. BEVIS, M. D.,

Chattahoochee, Fla.

Grateful surprise is often expressed by visitors to the Florida Hospital for the Insane and others interested when they really understand what is being undertaken by the State for the comfort and restoration of this most unfortunate class of Florida's citizenry. That the public generally may know more fully what is being accomplished in this great work it has been decided to briefly mention some of the most important and possibly the least known features of the care of the insane at Chattahoochee.

The hospital is located about one mile west of the Apalachicola River, a few miles from the highest surveyed point in Florida, on one of those prominent elevations in Gadsden county often referred to as the "mountains of Florida."

The State has eighteen hundred acres of this fertile land and the hospital buildings and grounds are near the western side of this acreage on a beautiful plateau. Many of these productive acres are in cultivation and yield surprisingly large amounts of vegetables and farm products. From the avenue leading to the entrance of the grounds the visitor gets a fine view of the surrounding country and the red hills and pines silently bear witness of the healthfulness of the location — a place ideally adapted by nature for the "wounded mind" to recuperate. The landscape is beautiful and wholesome to look upon.

The size, height and number of the buildings can but impress those approaching the hospital the first time as to the whole-hearted manner in which the State undertakes to take

care for its insane, and this favorable impression grows as the true conditions and the magnificent outlay are seen.

To give an idea of the size and extent of the buildings of the hospital the fact may be mentioned that the floor space of the buildings used for sleeping quarters and living rooms alone aggregate over four acres.

The hospital operates its own water, ice, and electric plants, sawmill, laundry, sewerage disposal plant, sewing rooms, mattress factory, dairy farm and piggery. The water plant is one of the best equipped small plants in the State. The drinking water is pumped fresh from an ever-flowing pure spring and is tested regularly by the State Board of Health and found much purer than the supply of many of our great cities who pride themselves on their excellent water. A nearby creek furnishes not only the water but the power also that pumps the water for general use to the top of the high tower building (erected by the United States Government in 1834) to supply the necessary force and pressure to properly distribute it.

At the mattress factory the mattresses used are made and renovated regularly by the patients.

In the sewing room are made all the clothes for the women, the shirts for the men, all the bed linen and such supplies for the use of the institution.

The dairy with its herd of over a hundred fine milk cows, fed almost entirely on feed grown on the hospital farm, furnishes fresh milk and butter for the delicate and sick patients, while the four hundred hogs raised annually go a long way toward supplying the pork, bacon and hams for the place.

In the near future the industrial department recently opened but now in operation



will be turning out sufficient brooms, chairs, tables, shoes, hats, and hosiery to meet our needs.

So great is the amount of food and supplies necessary to meet the needs of this ever-increasing population that, even with the most economical management, it costs the State over three hundred thousand dollars annually. With the least possible number of employees (often too few for doing the best work), the number on the payroll averages about two hundred sixty throughout the year, who are paid the sum of nearly eight thousand dollars monthly, or an average of about thirty dollars each per month with board, laundry and medical attention.

There are over sixteen hundred patients at the Florida Hospital for the Insane divided approximately as follows: Four hundred seventy-five white men, four hundred twenty-five white women, four hundred negro men and three hundred negro women. Each of these four natural divisions require special arrangement for the proper care and treatment to meet best their peculiar needs. Each is termed a department, with the following divisions or units hereinafter described:

- (a) Receiving and Infirmary Service.
- (b) General Wards.
- (c) Tuberculosis Group.

*The Receiving Hospital and Infirmary* is the large two-story brick building with the colonial porch in front as you turn after entering the grounds. It is used for white patients only. The two receiving wards are entered from the large wide hall on the first floor.

Each receiving ward has a capacity of seventeen beds. On the first floor are also the offices of the physicians, the drug-room, superintendent of nurses' office, kitchen, serving room and the nurses' dining room. On the second floor are the two infirmary wards, a suite of five rooms and bath for the nurses in that building, and the surgery with its rooms for instruments, operating, preparation, supplies, sterilizing and anæsthesia. Each of these two infirmary wards has

a capacity of eighteen beds, giving a bed capacity in this building of seventy beds for the sick and recent admissions. Colored patients have receiving and infirmary wards in their own buildings in their respective departments.

*The General Wards* are for those patients whose physical condition is such that they are not required to be in bed and, of course, the greater part of the hospital population is in this division. It is highly necessary that the patients be so classified that they may not only be more contented but more easily handled. Some are so mild that they enjoy privileges that would be most dangerous to consider for others. The classification separates the patients naturally into about six classes or groups on the general wards: (1) Mildest type; (2) mild type who are harmless but who are constantly under observation; (3) disturbed type who are not violent; (4) disturbed and violent or destructive; (5) epileptics; (6) idiots, senile and feeble. The first and last named occupy the lower floor wards. Many of the last group are not able to go to the general dining room and their meals are brought to them. The epileptics have low beds that prevent them getting hurt by falling from the bed at night. In case they have a convulsion they may slide off the bed on the floor without injury. On all these wards are well ventilated sleeping quarters and day-rooms and plenty of high, open porches properly arranged to protect the patients from violence but not obscuring their view. Each patient has a good, comfortable bed properly kept at all times. These wards are kept clean and sanitary even under the most trying circumstances that present themselves.

*The Tuberculosis Building* for white patients is one of the newest and most modern buildings on the grounds. It is a one-story wooden bungalow two hundred and eight feet in length, having a capacity of thirty beds. This building, like the receiving hospital and infirmary, is arranged one-half for each of the sexes, thus making two

separate units in one. At present the negro patients are kept on the spacious porches of their respective hospitals, but plans are being made for a more modern unit of this kind for them.

The color of the interior of the tuberculosis building is a soft natural green to offset the glare of this sunshiny building and make it cool and inviting even on the warmest days of summer. Contrasting with this so harmoniously is the white enamel trimming that gives everything about the place that clean, sanitary atmosphere. The walls are such that they can be cleansed in any of the usual ways real often without injury; all the corners are round to prevent dust collecting and make them more easily cleansed; all the facings are flush with the walls for the same reason, and the hardware is brass and takes a beautiful polish. The lights are the soft, indirect kind so restful to the eyes and so well adapted to this class of patients. The floor is that durable, marbleoid, waterproof covering over a solid base that makes it both agreeable and noiseless to walk upon as well as easily cleansed and sanitary. The porches have cement floors. The buildings are all heated by steam, but the day rooms in this building, where those not in bed sit, have in each a large open fire-place where always burns a fire if weather is cool enough during the day to make the fire an added comfort and cheer.

In front of this building is a beautifully planned garden where are getting started shady arbors of roses, wisteria and other vines and many evergreen trees and shrubs including the magnolia grandiflora. These with the concrete walks, shady nooks, seats, fountain and gold fish add much to the outdoor happiness of this class, making thereby more effectual the open-air treatment, careful nursing and diet this unit so lavishly supplies.

To get a line on the magnitude of the feeding of the above mentioned number of patients, imagine over five thousand meals being served from one kitchen daily. This is actually what happens every day in the year

at the Hospital for the Insane. Each of the four departments has a congregate dining room where all the patients eat whose physical condition will allow it. One has to see this vast crowd of more or less irresponsible persons eat in such an orderly manner to fully realize what careful, systematized handling of such people makes possible. Very few ever fail to eat their portion. The big task of preparation of the food is in charge of an expert dietitian whose knowledge of the value and the correct preparation of suitable things to eat is saving the State thousands of dollars annually and giving the patients the varieties of diet that individually give them the best chance to regain their former strength and mentality. Often the life of a patient and his chance for mental recovery depend more on the correct amount of the proper food at the right time than upon medical treatment proper.

Amusements and recreation for both patients and employees are factors in the handling of the insane that can not be overlooked. These are already a power for good and a part of the institutional life at Chattahoochee. The management encourages good music which is so well known to be a beneficial element in the treatment of mental and nervous diseases. In the last few months an orchestra with ten instruments has been organized and the already efficient brass band has been strengthened by the selection of employees with experience in both hospital and band work. The orchestra furnishes delightful music for the employees' dances on Monday nights, supplementing the moving pictures on Tuesday nights, for the patients' dance on Friday nights and on other occasions. Regular outdoor band practice, when the weather will permit, in the nature of a concert for the patients is much enjoyed. Every member of the band is an employee of the hospital and owns his instrument. The pictures on Tuesday nights, as far as is possible with the present method of obtaining same, are of such kind and character as will best amuse and instruct the patients without

introducing those scenes that tend to unduly excite or depress. The dances for the patients each week are always well attended. On these occasions employees dance with the patients of the opposite sex through alternating numbers on the program, and the employees together the others, thus giving the patients opportunity to dance for half the program if they wish. It is delightful to see the interest shown by the patients in anticipation of these events.

Regular walks or "hikes" are given the patients who are strong enough, when the weather is good, and during the spring and summer months much of the time is spent out in the open. Shady parks for them to sit in or wander through, properly observed and supervised, are being enlarged and improved for the coming season.

Religious services are held weekly for the patients by the chaplain, at which time excellent sacred music is furnished by a choir or chorus composed of the young ladies employed in the white female department as nurses. Many patients attend these services and a few go to services in the village.

*The Medical Staff* consists of a chief physician and three assistant physicians. Their entire time is at the service of the patients and employees. This gives each department a medical officer in charge. The superintendent is also a physician. His experience as assistant physician, in addition to his executive ability, has fitted him admirably for this position of trust and responsibility. A competent pharmacist and an experienced dentist in their work here make more effective the work of the medical staff.

On admission a careful examination and history are made of each patient. Nothing that tends to throw light upon the cause of the mental downfall is omitted. Specimens of blood, sputum, urine, and feces are examined as a routine measure immediately after admission, as well as spinal and other body fluids when indicated. The patient is also promptly immunized against typhoid fever and vaccinated against smallpox.

At meetings of the medical staff three times each week new cases are presented with the complete history and clinical findings. At this time every phase of each case presented is discussed by the members of the staff and the superintendent so that a correct diagnosis may be made and proper treatment instituted. Once each week similar meetings are held to pass upon the fitness of patients recommended by the attending physician for discharge.

The work of the regular medical staff is further augmented by a visiting staff composed of some of the State's best specialists in their lines, who make regular visits to the hospital quarterly, or oftener if needed, to give special treatment or to consult with the medical staff.

So by the fortunate combination of a high, healthy location with picturesque scenery, good water, correct sanitary conditions, proper food, diversional occupation, amusements, conscientious nursing and thorough, sympathetic medical attention, the best possible chance is given those of our State whose mental horizon is beset with shadows to be themselves once more.

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#### DUTIES OF A BOARD OF HEALTH.\*

J. H. COFFEE, M. D.,  
Ft. Meade, Fla.

The ideal result of the efforts of a Board of Health is the entire absence of preventable diseases; hence, the duties of a Board of Health necessarily have to do with the prevention of preventable diseases. The efforts of a Board of Health provided with sufficient funds and clothed with proper authority can reasonably be expected to bring about a happy condition. Anything which conserves the health of a community, at the same time conserves the wealth and happiness of that community.

Assuming that a Board of Health is fortunate in having a big, strong executive—a

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\* Read before Tri-County Medical Society in Lakeland, July 10, 1917.



man capable and willing and anxious to receive instruction, and brave enough to institute war, if needs be, to carry forward the great work of disease prevention, we come to a statement of these duties.

They may be considered under three heads: (1) Learn what to do. (2) Learn how to do. (3) Do it. The custom generally followed in selecting a Board of Health is to select a set of men who have no special ability for health work but who are good citizens and who love their fellowman well enough to make a sacrifice in order to make the world brighter and better. This set of men without bias and with an eye single to the end in view surround themselves with men capable of carrying on the work of public health. With this combination of talents the first duty is to learn what to do in order to conserve the health of the community. This leads us into the mysterious paths of the etiology of diseases. Even after we know positively the etiology of a disease in general, we are frequently at a loss to account for the cause of a particular case or epidemic. Some very fine work has been done along this line and the skill used in running down sources of infection have often been little short of marvelous, but even with the records of these cases before us and with the assistance of skilled health officers it is too often the case that it takes a great deal of valuable time to bring to light the source of the agent that is causing sickness and death.

In order to facilitate the work of a Board of Health the public must have confidence in the honesty of the Board and abiding faith in the ability of its workers. No institution is more at the mercy of public opinion than is a Board of Health, and certainly no institution more richly deserves the support and sympathy of the public than a Health Board which is honestly and earnestly performing its duties. Not only should the Board be familiar with the known things in prevention, but they should be eternally advancing with the world of science which is each day

converting the unknown into the known. It is not reasonable to expect the average Board of Health to spend much time in research work and, indeed, at the present time public health workers are far behind the research workers. We have long known just what causes malaria, how it is transmitted, and exactly what is necessary to entirely eliminate it, but while the ravages of this disease have been greatly decreased, yet current literature is full of variations of the treatment of malaria. We know that if we can keep the infected mosquito away from people, and infected people away from mosquitoes the problem is forever solved. We do not know how to accomplish this and we never shall until the public health workers win the respect and confidence of the public. Boards of Health could not do better than use their supreme effort to avoid even the remotest suspicion that graft, ambitions and jealousies exist in public health work. Education in this, as in all other walks of life, is the prime factor. Ignorance and its offspring, vice, present an obstruction which prevents the progress of all things good. When the soft white rays of education penetrate through suspicion, indifference, and hatred, then we shall see ignorance fleeing from knowledge and vice languishing for lack of support.

It is a duty of a Board of Health to get itself properly before the people and then with untiring patience teach them that which they must know if the people would be well and happy. The people must believe that a Board of Health is really unselfish if the members of the Board are to be able to earn their salt. There are already more health conservation measures than are being used and I believe that I am entirely within the bounds of truth when I say that from not one of them are we getting anything like its maximum possibilities for good. Many times we know what to do but we do not know how to do it.

The second duty, as we have outlined them, is how to do things, and by this I mean how

to do things that we already know about. It is indeed but a trivial matter to learn how to actually administer vaccination for small-pox or even typhoid fever, but it is entirely a different thing to learn how to get the people to submit to these operations. I believe that it would be a good idea for the State Board of Health of Florida to begin a campaign along this line in the following manner: advertise to the people that the Board has begun a systematic campaign against typhoid fever and that they will have a competent man in Lakeland on a certain date, in Bartow on the next and so until ten towns have been named to administer vaccination against typhoid fever, and that ten days later he will again visit these towns to administer the second injection and so on until the three injections have been given. This could be done all over the state and with the details properly worked out there is no doubt that there would be thousands immunized who would probably in no other way avail themselves of this wonderful achievement of science. While I believe that physicians throughout the state are urging this vaccination, yet people put it off and a specific appointment of this kind would call their particular attention to this important duty. A Board of Health should do things in a specific way and avoid generalities. Generalities make good reading matter, but they do not reach down into the insides of a man. He believes in a general way that maybe vaccination against typhoid fever is a pretty good thing and that some day when he gets time he will take it on. I have had several tell me that a year or more ago, but somehow that time has never come. The best way to do anything for or to a man is first get close to your man.

The third and last duty of a Board of Health is to do things. While writing and talking are necessary in all great undertakings, yet what the average man likes is action—doing things. I believe that one good, hardworking man going out among the people can serve a better purpose than two

men writing at desks. I have seen cases of malaria in homes where they assured me that no mosquitoes ever came in at all and it was a very easy matter to show them quite a number under the bed and behind wash-stands or dressers and in closets. It has been said that people have to be made to do things which they already know is to their interest to do. I do not subscribe to this. They do not know it to be to their interest but merely half believe it. Once you let them know that a thing is best for their health and they will do it more often than not. The duties of a Board of Health may be summed up in three words—Educate, Illustrate, Demonstrate.

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#### ERYTHEMA SCARLATINIFORME.\*

G. H. EDWARDS, M. D.,

Orlando, Fla.

Erythema Scarlatiniforme is a name given to an eruption arising from a large number of causes and varying considerably in character, but having a tendency to simulate the rash of scarlatina. This condition has been described as an idiopathic disease, but it has so often been demonstrated to be a symptom only of other disorders that its existence as an independent affection may well be doubted. Several French authors divide this erythema into an acute and subacute type. Both of these are always secondary to infectious diseases, autotoxæmia, or to medicinal or food intoxications. The subacute form is differentiated by the mild constitutional disturbances, while the rash has the tendency to be more diffuse, desquamation may persist longer and recurrences are more frequent. While it is often clinically convenient to make a difference between acute and subacute forms, there seems to me no good etiological grounds for making such a diagnosis, as a given drug or certain form of intoxication may produce an acute type in one individual and a sub-acute type in another.

Idiosyncrasy is a most important factor in

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\*Read before the Orange County Medical Society at Orlando, October, 1917.

the etiology of those forms of erythema which appear in certain predisposed individuals as a result of causes totally insufficient to produce the same phenomena in most persons. The exciting factor is usually, if not always, some form of toxæmia. Among many causes reported are: infectious diseases, septicæmic conditions, toxmias of varied origins, peritonitis, rheumatism, ague in children, gonorrhea, abscess, empyema, uræmia, tuberculin injections, certain articles of food, and many drugs. The causes are sometimes external, as when following mercurial inunctions, exposure to high temperature, etc.

The rash may be preceded by a day or two of fever and other evidences of constitutional disturbance, or it may appear suddenly without other premonitory symptoms. The exanthem spreads rapidly and in a few hours, or at most in two or three days, reaches its full development. The rash may be punctiform, macular, or diffuse, and the color may be any of the shades of red, but it is usually a bright scarlet. In some instances it has all the appearances of a typical scarlatinal rash, except that it may begin on any part of the body, often sparing the face, and that desquamation begins much earlier (three or four days after the onset of the malady) than in scarlatina. There are usually some fever, malaise, and other constitutional disturbances that may vary greatly in intensity, depending upon the disease, of which the exanthem is a symptom. The mucous membrane of the mouth, the tongue, and the fauces may be reddened or denuded of epithelium, but the characteristic strawberry-tongue of scarlatina is wanting. The nails and the hair may be shed, but only in exceptional cases. Desquamation usually begins in from two to six days, sometimes before the disappearance of the rash, and it may even occur on surfaces which had not perceptibly been reddened. The scales are usually furfuraceous, but they may be large and abundant; in rare instances, the entire

epidermis of the hand may be shed in glove-like form.

It is most important to distinguish this rash from that of scarlet fever. Commonly the diagnosis is not difficult, as in erythema scarlatiniforme; the constitutional symptoms are slight; the rash appears early, beginning on any part of the body; desquamation begins early and is extensive; the fauces, though red, are not swollen; and there is absence of the strawberry-tongue and of all history of contagion. Occasionally the rash may closely resemble that of measles, but the history of the case and the absence of other symptoms peculiar to these affections should make the diagnosis clear. As a rule, an examination of the rash alone is not sufficient, and a diagnosis of erythema scarlatiniforme should not be made until the other exanthemata have been considered and excluded. In scarlet fever the invasion is more sudden, characterized by vomiting as well as sore throat and a rapid rise of temperature. In many cases an eruption appears first in the mouth, on the cheeks, hard and soft palate and pharynx, pulse is always very rapid and of high tension, and there is a high temperature. The eruption appears within eighteen to thirty-six hours as an erythema, appearing first on the sides of the neck, breast and back. In a few hours it spreads over the entire body, most intense where the skin is kept warm, as on the back and flexures of the limbs. The upper part of the face is red but the skin around the mouth and chin is rarely involved. Desquamation rarely begins inside of six days and then only after the eruption fades. The strawberry-tongue is present.

The case which I wish to report was due to the ingestion of urotropin. The patient had been accustomed at the beginning of an acute purulent coryza to take from twenty to thirty grains of urotropin, sometimes alone and sometimes with a little quinine and aspirin, but always with a rapid cessation of symptoms. Several times after this medication an eruption has appeared upon the feet



and abdomen, itching intensely and desquamating within two or four days. This time the coryza was so marked that the individual repeated the dose of urotropin in four hours, making a total of fifty grains. Eight hours later a scarlatiniforme eruption appeared upon the dorsum of the feet and between the toes, itching intensely. Ten hours later it appeared on the abdomen and spread very gradually, taking five days to cover the body. No part, not even the scalp, was free. The mucous membrane was not involved until the third day. The pulse was comparatively slow and of low tension; the temperature gradually rose on the third day to  $102\frac{1}{2}$ . The kidneys were not affected. Desquamation began on the dorsum of the feet within forty-eight hours after the eruption appeared and even before it began to fade. Besides the increased amount of urotropin taken this time, possibly one reason for the greater intensity of the erythema was the presence of a marked posterior nasal infection, the most severe the individual had ever had, the toxæmia from this infection possibly playing a part in the eruption. The writer, in conjunction with several other physicians, was tempted, despite the absence of any history of scarlatinal exposure, to make a diagnosis of scarlatina. However, the slow extension of the rash, its abnormal location in beginning, absence of the strawberry-tongue, and slow invasion, decided us in our diagnosis of erythema. This has presumably been clinically confirmed since now five weeks after illness and with desquamation still in progress in the scalp and on the feet and hands, no scarlatinal cases have developed.

### ORAL INFECTIONS AND THEIR RELATIONS TO SYSTEMIC DISORDERS.\*

W. H. COKER, D. D. S.,  
Pensacola, Fla.

In the past little attention has been paid to infections in the oral cavity by the medical

profession, but I am glad to say that they are realizing their significance more and more, and we are finding ourselves being sought in consultation, discussions and in social ways are no longer looked upon as high-class mechanics by physicians, but as professional men.

As we all well know the average mouth is a cesspool of bacteria and a break in the tissue of the mouth opens a gateway to the circulation for disease-forming germs. Can any of you point out a more abused organ than the oral cavity?

The most common local infections are dento-alveolar abscesses and pyorrhea. There has been so much said of pyorrhea and its treatment here of late that I will confine my paper mostly to dento-alveolar abscesses.

They are located at the apex of the teeth in the periodontal membrane. This membrane is composed of a network of connective tissues, elastic fibers, nerve fibers, blood vessels, etc., and is confined in a bony cavity; it acts as a cushion to the tooth in mastication as well as being an organ of nutrition.

When an abscess develops within this socket there is no channel of escape until the pus finds the path of least resistance and forms a fistulous opening. In a great many instances the bone tissue has a great resistance which prevents the escape of the pus, and naturally there is only one way left for nature to eliminate the poisons formed, this taking place by absorption and elimination through the kidneys. Not only does the pus find its way into the system by absorption, but it is actually forced into the circulation through the periodontal blood vessels by the occlusion of the teeth in mastication. The germs usually found in alveolar abscesses are staphylococci, streptococci and pneumococci, the most important of which are the first two mentioned. If the staphylococci predominate, we usually have a circumscribed abscess, and the danger of absorption is much less. If the streptococci, we have a diffused abscess and a much larger area infected, therefore a greater amount of pus absorbed into the cir-

\*Read before the Escambia County Medical Society, at Pensacola, December, 1917.

culation. Should the germ be the streptococcus viridans (green) and get into the circulation, there is a possibility that the germ will eventually find its way into synovial membrane of the joints and the consequence will be an infected rheumatism.

There is a strain of streptococci found in the saliva known as the streptococci salivarius, which is also found as a terminal infection in endocarditis and septicaemia.

Gilmer and Moody call attention to the occurrence of alveolar abscess in epidemic form when streptococci infections of the upper respiratory tract are prevalent. Rosenow, of Rochester, Minn., gives a table percentage of lesions in the various organs in animals following intravenous injections of streptococci from a wide range of sources, which may be regarded as an index of the liability of the various organs to streptococci infections. The joint lesions occur more often than lesions in other organs, the average being twenty-seven per cent. Lesions in the stomach average twenty per cent, valves of the heart fourteen per cent, myocardium twelve per cent, and skeletal muscles twelve per cent. Rosenow claims this corresponds in a general way to the occurrence of infections in the same organs in man.

Abscesses at the roots of teeth frequently exist for months or some times years before detection. It is very easy to diagnosticate an acute focal infection at the root of a tooth when the gum is red and swollen and painful or a fistula discharging pus. There are approximately fifty-four roots existing in the adult mouth, any one of which may be a focus of infection, therefore it is not difficult to understand why a primary focus of infection may be overlooked. We should not depend merely on a clinical examination; we must employ more scientific methods to discover infected areas.

If the primary focus of infection exist, or probably exist in the mouth, the physician and dentist should meet in consultation in order to determine whether the teeth should be treated or extracted, each should detail the

result of his examinations so the patient may receive the best results. I do not believe in wholesale extracting of teeth, but when a tooth is beyond crowning or has an abscess that will not respond to treatment, I *do* believe that the patient is far better off with that tooth out. Daland states it is wiser to sacrifice a tooth than to sacrifice the patient.

I am glad to say that the American dentist is recognized as the foremost in the world, largely through originality, invention, industry and mechanical devices. The same energy in intelligence directed towards diagnosis, prevention and cure of oral sepsis will yield the same brilliant results. The eyes of the medical world are upon us — we hope to be equal to the test and prove to them that we are scientific men.

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#### CONDUCTIVE ANAESTHESIA OR NERVE BLOCKING.\*

B. V. DANNHEISSER, D. D. S.,

Pensacola, Fla.

I do not know of any one thing that has done more to revolutionize dentistry than has conductive anaesthesia. The dread of the pain endured in the dental chair is inherent in the human race. Throughout the recorded histories of all people are seen evidences of attempts at its alleviation from the very crudest efforts of the ancients to our modern anaesthesia methods of the present.

During the last few years, a great awakening has taken place among our profession, due partly to the earnest efforts of our research institutes and partly to the demand of the laity for more humane treatment. We realize more every day that no operation performed on the human anatomy causes more drain on the nervous system than those performed in the dental chair. While minor operations in and about the mouth have been done and are being done painlessly by the use of cocain, nitrous oxide, somnoform and other such drugs, these operations are always

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\*Read before the Escambia County Medical Society, at Pensacola, December, 1917.

accompanied to a certain extent by shock. This shock is done away with in the application of this newest form of anæsthesia. I refer to the use of novocain and suparenin administered hypodermatically.

This anæsthetic, if properly prepared and administered, is harmless in its effects, and having as its base a sterile normal salt solution, it is introduced into the tissues without causing any pain or swelling. The solution being isotonic, it is quickly taken up by the blood stream.

Compared with cocain, novocain is only one-seventh as toxic, has the same anæsthetizing power, and does not cause any tissue lesion. It has the additional advantage over cocain in that poisoning from novocain is practically unknown. While a 2 per cent cocain solution is considered as strong as may be used without danger of bad after effects, novocain may be used as high as 10 per cent. The circulation and respiration are unaffected, the heart's action is not influenced and there is no increase in blood pressure after its administration in appropriate doses.

The list of operations performed under this anæsthesia includes practically every type which comes to the attention of the dentist and the oral surgeon. Among such operations, I would include extractions, curettment of sockets, scalding of pyorrheal teeth, root resection, cyst operations, tumor removals, bone chiseling, abscess treatments, reduction of fractures, preparation of sensitive cavities, pulp removal and immediate relief of odontalgia. In my use of novocain suparenin, I can report complete success in 80 per cent of the cases treated. I wish to state that I did not make a selection of cases in which to use the anæsthetic, but used it whenever a patient feared that the operation would cause too much pain and in a few cases where the use of it was not really indicated. I blame the 20 per cent failures not to any fault of the drug, but to either a faulty technic or undesirable patients. By

undesirable patients I mean hysterical and extremely nervous people.

Novocain suparenin possesses the following advantages over other local anæsthetics:

1. It is not dangerous to the patient's life.
2. Nearly all operations incident to general practice can be performed under it.
3. An assistant is not necessary.
4. The patient needs no preparation.
5. Little time is consumed.
6. The patient can cooperate.
7. A simple and inexpensive outfit is required.
8. It can be used on patients of all ages.

There are two most important things necessary to success in use of novocain. They are asepsis and a thorough knowledge of the anatomy of the structures involved. While we may blame failures on the anæsthetic itself, a careful checking up will show that the fault is either an imperfect technic or a failure to make the injection at the proper point.

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### PROPAGANDA FOR REFORM.

ACTIVE PRINCIPLE OF LEECHES. — The principle in the buccal secretion of the leech which prevents the clotting of blood is herudin, a deuterio-albumose. (*Jour. A. M. A.*, March 24, 1917, p. 931.)

ARSPHENAMINE.—No, this is not a new chemical; it is simply the name adopted by the Federal Trade Commission for the hydrochloride of 3-diamino-4-dihydroxy-1-arsenobenzene—in other words, salvarsan. The three firms which have been licensed to manufacture this drug are permitted to have their own trade names for it, but the official name "arsphenamine" must be the prominent one on the label of all brands. Hence physicians should at once make it a point to learn and use the name "arsphenamine." (*Jour. A. M. A.*, Jan. 19, 1918, p. 167.)

BETAINE HYDROCHLORIDE. — It contains 23.8 per cent absolute hydrochloric acid and 8 grains corresponds to about 18 minims of diluted hydrochloric acid. In solution betaine



hydrochlorid dissociates into hydrochloric acid, but it is not so efficient in aiding the action of pepsin as an equivalent amount of hydrochloric acid. (*Jour. A. M. A.*, March 24, 1917, p. 931.)

**BIOLOGIC THERAPY IN THE WAR.**—According to G. W. McCoy, Director Hygienic Laboratory, U. S. Public Health Service, there are five biologic products—vaccine virus, diphtheria antitoxin, tetanus antitoxin, antimeningococcus serum, and antityphoid vaccine—which may be regarded as indispensable in connection with conditions which prevail when large bodies of men are brought together. The firms manufacturing these products can, if need be, meet the demands of our own army and civilian population as well as those of our allies. McCoy believes that with the good sanitary conditions that may be expected to prevail in our concentration camps, the need for vaccine agents not thoroughly tried out, such as antidyentery serum, antipneumococcus serum, and vaccines against dysentery, cholera and epidemic meningitis, should not be extensive with the possible exception of the meningococcus vaccine. (*Jour. A. M. A.*, May 12, 1917, p. 1413.)

**CACTINA PILLETS.**—According to the manufacturer of Cactina Pillets (The Sultan Drug Co.), "cactina" is "invaluable in all functional cardiac disorders such as tachycardia, palpitation, arrhythmia, and whenever the heart's action needs regulating or support." The manufacturer gives no information as to the mode of action of "cactina," but states that it is totally unlike that of digitalis. An examination of the literature indicates that *Cactus grandiflorus* is therapeutically inert, and no one except Mr. Sultan of the Sultan Drug Company claims to have isolated an active principle of it. The Council on Pharmacy and Chemistry examined the literature relating to cactus and certain proprietary preparations, including Cactina Pillets, alleged to be made from cactus, and reported that the literature does not afford a single piece of careful, pains-

taking work which lends support to the claims made for Cactina Pillets. Since then, Hatcher and Bailey examined genuine *Cactus grandiflorus*, and also found that the drug was pharmacologically inert. (*Jour. A. M. A.*, Jan. 19, 1918, p. 185.)

**CONTROL OF INTESTINAL BACTERIA.**—A recent investigation indicates that the direct feeding of bacterial cultures of lactic acid producing organisms had almost no influence on the intestinal flora. On the other hand the administration of milk sugar (lactose) brought about a marked change in the intestinal flora. It appears, therefore, that the beneficent action of milk cultures is dependent on the lactose and not on the bacteria which they contain. (*Jour. A. M. A.*, March 24, 1917, p. 918.)

**DIONOL.**—If physicians take the word of the Dionol Company, the therapeutic possibilities of Dionol are apparently limited only by the blue sky. Even the company admits that "the unprecedented range of action" of this marvel "may come as a surprise." A glance over the published case reports confirms the inference. Dionol is furnished in two forms: as an ointment and as an emulsion. Dionol itself is a sort of glorified petrolatum, the use of which is said to prevent the leakage of energy from the nerve cells, and by overcoming the short-circuiting always said to be present in inflammation, is asserted to accomplish its wonders. (*Jour. A. M. A.*, Jan. 26, 1918, p. 257.)

**DATING OF BIOLOGIC PRODUCTS.**—William H. Park, Director, Bureau of Laboratories, Department of Health, City of New York, endorses the recently-adopted requirements of the Council on Pharmacy and Chemistry that biologic products to be acceptable for New and Nonofficial Remedies must bear a statement of their date of manufacture. He believes that these requirements might well be made more specific and stringent. The rules of the New York Health Department governing the distribution of biologic products are: 1. The label on all

bacterial vaccines must state the date the suspensions are made, standardized and killed. 2. The label on all serums other than antitoxin shall state the date of bleeding. 3. The label on antitoxins shall give the date when the preparation was last tested. 4. The label on vaccine virus shall have the date when the virus was last tested. Dr. Park states that there is no intention of extending the potency date of bacterial vaccines (four months or of serums (nine months) other than the antitoxins until there are very specific data on which to act. For vaccine virus 100 per cent of "takes" is demanded. (*Jour. A. M. A.*, May 12, 1917, p. 1428.)

EXAMINATION OF AMBRINE AND VARIOUS PARAFFINS.—P. N. Leech, of the A. M. A. Chemical Laboratory, reports on the composition and properties of Ambrine and the various preparations proposed for the treatment of burns. He finds that the French proprietary Ambrine — exploited in the United States as Hyperthermine and Thermozone—is essentially paraffin in which a small amount of a fatty oil and asphalt is incorporated. A preparation similar in composition but superior to Ambrine in physical properties may be made by dissolving 3 to 5 drops asphalt varnish in 1.5 c. c. of olive oil and adding this to 97.5 gm. melted paraffin melting at 47.2 c. It is probable that for most purposes simple paraffin will answer just as well as Ambrine or the mixtures proposed in its place. Whether used alone or in mixtures, the physical properties of the paraffin are most important. Paraffin U. S. P. will not answer, and hence the properties of many commercial brands of paraffin were determined and the best products are designated. (*Jour. A. M. A.*, May 19, 1917, p. 1497.)

FROSTILLA.—The lotion for chapped hands is, according to the Druggists' Circular, a quince-seed mucilage containing alcohol, glycerin and perfume. (*Jour. A. M. A.*, May 5, 1917, p. 1341.)

HEXAMETHYLENAMIN IN PYELITIS. — I. A. Abt advises caution in the administration

of hexamethylenamin in the pyelitis of infants. It should be under continuous observation and its use should be continued for an extended period. The urine should be frequently examined for blood. Abt has more than once seen cases of fatal nephritis which, he believes, is due to the overuse of hexamethylenamin. He advises that, if given to infants under one year of age, it should be given in one grain doses followed by water. This dose may be repeated four or five times daily (*Jour. A. M. A.*, April 14, 1917, p. 1100).

HEMO-THERAPIN.—The Council on Pharmacy and Chemistry reports that, according to the Hemo-Therapin Laboratories, New York, Hemo-Therapin is a "combination of highly refined creosols and phenols (which have been detoxicated by special processes), with salts of iron, potassium, sodium, phosphorus and calcium in minute but physiologic proportions—the solution as a whole being designed to approximate closely in various fundamental details the chemistry of the blood." No statement is made, however, as to the quantities of the several ingredients, nor is any information given as to the identity of the "creosols" and "phenols," or as to the nature of the processes whereby these are "detoxicated." The Council explains that the Hemo-Therapin Laboratories ask physicians to believe that the occasional intravenous administration of this liquid will benefit or cure a long list of ailments, including erysipelas, septicemia, pyemia, puerperal infection, malaria, pneumonia, typhoid fever, diabetes, chronic Bright's disease, goiter, arteriosclerosis and locomotor ataxia. The testimonials which are presented for the claims bear a striking likeness to those found in "patent medicine" almanacs. One of the cases is a woman who was bitten by a snake seventeen years ago and who, on the anniversary of the bite, suffers severely from the original bite. (*Jour. A. M. A.*, Jan. 5, 1917, p. 48.)

K—Y LUBRICATING JELLY. — The composition of this proprietary has not been

divulged. Probably a simple tragacanth jelly will produce the same effects as this proprietary preparation. At the German Hospital, Philadelphia, a jelly made from tragacanth, 3 gm., glycerin, 25 c. c., phenol, 1.5 gm., with water to make 300 c. c. has been used for years. (*Jour. A. M. A.*, May 12, 1917, p. 1430.)

**MORE MISBRANDED NOSTRUMS.**—The following "patent" medicines have been found to be marketed in contravention of the requirements of the U. S. Food and Drugs Act, chiefly because the medical claims were found untrue: Whitehall's Megrimine, capsules containing acetanilid, caffeine and salol (in one instance also capsules containing antipyrine and capsicum). Brown's Blood Treatment, a liquid containing mercury and iodid. Classe's Great Penetrating Liniment, an alcoholic solution of ammonia, chloroform, opium, camphor, oil of sassafras, oil of origanum and a thujone-containing oil. Brown's "935" Injection (formerly H. W.), a dilute solution of acetate and sulphate of zinc. (*Jour. A. M. A.*, May 12, 1917, p. 1427-8.)

**NUTROLACTIS AND GOAT'S RUE.**—Drugs which stimulate the secretion of milk are unknown to science. Yet the proprietary Nutrolactis (The Nutrolactis Company) is claimed to increase the milk supply of nursing mothers. Since dependence on a preparation of this kind is liable to cause neglect of the only means of increasing the milk supply of nursing mothers—care of the general health and a sufficient quantity of proper food—Professor A. J. Carlson and Marian Lewis, of the Hull Physiologic Laboratory of the University of Chicago, studied this proprietary and the drug goat's rue (*Galega officinalis*), which the proprietors of Nutrolactis hint as being the potent constituent, to determine their effects on nursing animals with the intention of extending the study to nursing mothers if the animal trials warranted this. The animal experiments showed that neither Nutrolactis nor goat's rue had any effect on the milk supply of

nursing goats or dogs. The Council on Pharmacy and Chemistry, which had caused the study to be made, endorsed the work of Carlson and Lewis, and held that the claimed galactagogue effects of Nutrolactis and the drug goat's rue had not been substantiated. (*Jour. A. M. A.*, May 26, 1917, p. 1570.)

**NEED FOR PATENT LAW REVISION.**—The Council on Pharmacy and Chemistry publishes a report prepared by its Committee on patent law revision, which is an appeal for an amendment of the patent law which governs the issuance of patents on medicinal preparations, and more particularly for a revision on the procedure under which such patents are issued. The report points out that to increase our national efficiency, the government must protect and stimulate science, art and industry, and at the same time curb waste of the country's resources; and that, to this end, the patent office should encourage discoveries which go to increase national efficiency, and refuse patent protection when such protection is not in the interest of national efficiency, conservation of energy and material resources. The report presents a considerable number of specific instances which demonstrate that patent protection has been given where it was not deserved and not in the interest of the public. The report concludes with a reference to the investigation of a patent granted for a preparation of secretin, apparently without any attempt to confirm the highly improbable claims of the patent applicant. (*Jour. A. M. A.*, Jan. 12, 1918, p. 118.)

**OUR ARCHAIC PATENT LAWS.**—The reports of the Council on Pharmacy and Chemistry on Secretin-Beveridge and the Need for Patent Law Revision are opportune. At the request of the National Research Council the "Patent Office Society," an association of employees of the U. S. Patent Office, has created a committee to study the U. S. Patent Office and its service to science and to arts. There is no question that one of two things is needed: either a radical change in the patent law itself or the



application of more brains in its administration. Now the United States Patent Law is too often used to obtain an unfair monopoly of a medicament or to abet quackery. (*Jour. A. M. A.*, Jan. 12, 1918, p. 95.)

**PATENT MEDICINE PROSECUTIONS UNDER THE FOOD AND DRUGS ACT.**—The following information was brought out in connection with prosecutions by the Federal authorities chiefly under that portion of the Food and Drugs Act which provides penalties against misleading, false and unwarranted therapeutic claims: Dr. Porter's Antiseptic Healing Oil was found to be essentially a solution of camphor and carbolic acid in cottonseed oil. It was claimed to be an excellent remedy for cuts, sores, old chronic ulcers, corns, bunions and a preventive of whooping cough, diphtheria and tuberculosis. Ballard's Horehound Syrup Compound was sold "For Consumption, Coughs and Colds" and other diseases. Dr. Shoop's Night cure was claimed to promptly cure ulceration, inflammation or congestion of the womb, leucorrhœa, painful ovaries and other female diseases. It was found to be a suppository containing zinc carbonate, zinc sulphate and boric acid in a cacao butter. Dr. Shoop's Cough Remedy was found to be a syrup containing ammonium benzoate and probably white-pine tar and gum. Dr. Shoop's Restorative was sold for the cure of all diseases of the stomach, liver and blood and still other diseases. Father John's Medicine was advertised as a consumption "cure." Dr. Shoop's Twenty-Minute Croup Remedy was found to be a syrup containing glycerine and a small amount of salicylic acid. Bad-Em Salz was found to consist of sodium chloride, sodium sulphate, sodium, sodium bicarbonate and a small amount of tartaric acid. It was sold with claims suggesting that it was derived from European springs and that it dissolved gallstones and gravel in the kidneys or bladder. Kennedy's Cal-Cura Solvent was a water-alcohol liquid containing 2.44 per cent potassium acetate, 16.75 per cent alcohol, 52.46 per cent cane

sugar and vegetable matter resembling mint, cardamom and boneset. From the claims which were made one would get the impression that there could be few ills that it would not cure. (*Jour. A. M. A.*, Nov. 4, 1916, p. 1385-6.)

**PIL. CASCARA COMPOUND-ROBINS** (A. H. Robins Company, Richmond, Va.). The Council on Pharmacy and Chemistry reports that Pil. Cascara Compound-Robins is an example of the innumerable mixtures of well-known drugs having nothing in the way of originality or of special therapeutic value to recommend them. The claim that the pills contain no belladonna when they admittedly contain hyoscyamus is, in view of the similar action of these two drugs, a manifestation of ignorance on the part of the manufacturer or an effort to impose on the medical profession. The promotion of this mixture as "an ideal aid to any remedial agent when a mild, medium or strong alimentary stimulant is needed" is a slur on the intelligence of physicians. The Council finds Pil. Cascara Compound-Robins not acceptable for New and Nonofficial Remedies. (*Jour. A. M. A.*, Jan. 27, 1917, p. 303.)

**PREPARATIONS OF THE PITUITARY GLAND.**—The last edition of the Pharmacopeia, recognizing that the best attested field of usefulness for pituitary extracts is in obstetrics, adopted the test of their activity on the uterus of the guinea-pig according to the method of G. B. Roth, of the U. S. Hygienic Laboratory. Roth now reports on the activity of seven commercial samples, the products of five American firms. Four of the samples were found of Pharmacopeia strength; the other three were much weaker. Those preparations which have been accepted by the Council on Pharmacy and Chemistry for New and Nonofficial Remedies corresponded to the pharmacopeial requirements. Roth's work shows that the blood pressure method for determining the activity of pituitary preparations is not a satisfactory method for determining the ac-

tivity of a preparation on the uterus. (*Jour. A. M. A.*, May 5, 1917, p. 1325.)

**RHEUME OLUM.**—The Council on Pharmacy and Chemistry reports that Rheume Olum (The Rheumeolum Chemical Co., Seattle, Wash.) is said to be composed of camphor 7 per cent (chloral hydrate 7 per cent, menthol 2 1-8 per cent, methyl salicylate 25 per cent, oil cajuput 2½ per cent, oleoresin, capsicum, lanolin, white wax, "qs." The council found Rheume Olum unacceptable for New and Nonofficial Remedies because the amount of the potent oleoresin of capsicum was not declared, because unwarranted therapeutic claims were made, because the name was nondescriptive of its composition and therapeutically suggestive and because the fixed formula was considered irrational. (*Jour. A. M. A.*, March 17, 1917, p. 865.)

**SALVARSAN IN TABES WITH OPTIC ATROPHY.**—Some assert that salvarsan occasionally produces optic atrophy; others with extensive experience believe that it has no injurious effect on the eye. If given at all, it should be administered early in the disease. (*Jour. A. M. A.*, May 12, 1917, p. 1430.)

**SECRETIN-BEVERIDGE AND THE U. S. PATENT LAW.**—In 1916, A. J. Carlson and his coworkers demonstrated that commercial secretin preparations contained no secretin, and that secretin administered by mouth or even into the intestine was inert. Yet a U. S. patent was subsequently issued to James Wallace Beveridge, for a process of preparing secretin preparations which would contain secretin when they reached the consumer, and in a form resisting destruction in its passage through the stomach. At the request of the Council on Pharmacy and Chemistry, A. J. Carlson and his associates studied the stability of the secretin made according to the Beveridge patent. The investigation shows that the patent gives no process for the manufacture of commercially stable secretin preparations, nor any means for preventing the destruction of secretin by

the gastric juice when administered orally. (*Jour. A. M. A.*, Jan. 12, 1918, p. 115.)

**SURGODINE.**—The A. M. A. Chemical Laboratory having found Surgodine (Sharp and Dohme) to contain 2.51 gm. free iodine (instead of 2.25 per cent as claimed), and 1.78 gm. combined iodine (probably chiefly hydrogen iodide), the Council on Pharmacy and Chemistry reports that it is essentially similar to the official tincture of iodine except that it is considerably weaker and, instead of potassium iodide, it presumably contains hydrogen iodide and probably ethyl iodide to render the iodine water-soluble. Its composition, however, is secret. The Council held Surgodine inadmissible to New and Nonofficial Remedies because its composition is secret; because the therapeutic claims made for it are exaggerated and unwarranted, and because it is an unessential modification of the official tincture of iodine. Surgodine is a good illustration of the economic waste inseparable from most proprietary medicines. While the free-iodine strength of Surgodine is only about one-third that of the official tincture, its price is between two and three times as high. (*Jour. A. M. A.*, Jan. 26, 1918, p. 257.)

**SUCCUS CINERARIA MARITIMA.**—In agreement with the report of the Council on Pharmacy and Chemistry holding the claims made for Succus Cineraria Maritima (Walker) unfounded, the federal government charged that the claim that by dropping this preparation into the eye cataract may be cured was false and fraudulent. In February, 1916, the Walker Pharmacal Company pleaded guilty. Since the government's prosecution, brought under the Food and Drugs Act, affects only the claims made on the trade-package of a preparation, the admittedly false claims were still made in circular letters sent to physicians as late as October, 1916. (*Jour. A. M. A.*, March 17, 1917, p. 864.)

**TARTRATES IN NEPHRITIS.**—While the vegetable acids, such as citrates, burn to alkali in the body, the tartrates are not so

converted, and leave the body nearly in their original form. Underhill and others have shown that tartrates in large doses can cause tubular nephritis in animals. While human beings tolerate without apparent kidney disturbance small doses of tartrates, either given medicinally or as they occur in baking powders and in certain foods, and while it would probably require very large doses to cause kidney inflammation, it would seem inadvisable to give food rich in tartrates or to give medicinally large doses of tartrates in nephritis. (*Jour. A. M. A.* Nov. 25, 1916, p. 1601.)

**THE CARREL-DAKIN WOUND TREATMENT.**—William H. Welch writes that he was most favorably impressed with the Carrel treatment of wounds, and believes that Carrel should receive credit for calling attention to the possibility of the sterilization of infected wounds by chemical means. He holds that while undoubtedly the technic of the Carrel treatment is elaborate and requires an intelligence and skill on the part of the surgeon which can not be counted on for the average surgeon, and that while the preparation of the neutral solution of sodium hypochlorite also requires chemical skill, surgeons should acquaint themselves with the principles and technic, and try to overcome the difficulties of applying the treatment. (*Jour. A. M. A.*, Dec. 8, 1917, p. 1994.)

**THE SARGOL CASE.**—The exploiters of Sargol, the get-fat-quick nostrum, were found guilty of fraud and were fined \$30,000 after promising that the business would be discontinued. Sargol was made by Parke, Davis and Co. at a price of 53 cents to 78 cents per thousand tablets. Sargol was stated to contain extract saw palmetto, calcium hypophosphite, sodium hypophosphite, potassium hypophosphite, lecithin, extract nux vomica. The trial is said to have cost the United States over \$100,000. Although the business was palpably fraudulent, although the claims made for the nostrum were palpably false, the defendants were able to employ physicians to go on the stand

and swear that Sargol was a "flesh builder" and "bust developer." (*Jour. A. M. A.*, March 24, 1917, p. 927.)

**VENOSAL.**—The Council on Pharmacy and Chemistry reports that Venosal, sold by the Intravenous Products Company, Denver, Colo., is inadmissible to New and Non-official Remedies because its chemical composition is indefinite; because the therapeutic claims are exaggerated, and because the composition is unscientific. Venosal is a solution of sodium salicylate containing also colchicum and an insignificant amount of iron. Since it is possible to obtain the salicylate effects promptly and certainly by oral administration, the inherent dangers of intravenous medication render its routine employment unwarranted. At this time, when economy is a national policy, a further objection to the use of Venosal is the unnecessarily high expense of Venosal itself and the administration. (*Jour. A. M. A.*, Jan. 5, 1917, p. 48.)

**WHAT AILED HIM?**—A druggist wants to know what ailed the patient for whom the following was prescribed: Calomel 1 grain, potassium iodide 4 drachms, potassium bromide 3 drachms, potassium citrate 5 drachms, tincture of aconite 2 fluidrachms, wine of ipecac 1 fluidounce, chloroform water to make 3 fluidounces. Without venturing a guess regarding the patient's illness, it is suggested that if anything new was wrong with the patient after he took the medicine, the case may be diagnosed as one of misplaced confidence, either the physician's misplaced confidence in drugs or the patient's misplaced confidence in the physician. (*Jour. A. M. A.*, Nov. 18, 1916, p. 1541.)

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The skyscraper goes up stone by stone, brick by brick, foot by foot, day by day, slowly. There is no other way to build it. Europe's war food shortage must be made up by individual Americans through saving bit by bit, ounce by ounce, day by day, persistently. There is no other way to do it.



## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or P. O. Box 136, Jacksonville, Fla., U. S. A.

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**Next Meeting — Tampa — May, 1918**

## MOBILIZING THE PROFESSION FOR WAR.

Until the entire medical profession of the United States, or at least those who are mentally and physically fit and within the age limit, are mobilized within the Medical Reserve Corps of the United States Army, not until then can we give to the Surgeon General that efficiency which he so badly needs in having a large body of medical officers upon whom to draw.

You may never be called, at the same time your joining the Medical Reserve Corps and placing your services at the command of your country, clearly indicates the patriotism which the medical profession, as a whole, should evince and which we must manifest if we are to win the war.

Every doctor must realize that success depends upon a carefully selected and thoroughly trained body of medical officers. By careful selection, we mean the placing of a medical officer in a position where he is best fitted for the service, and only by having an immense corps or the entire profession mobilized upon a war basis, can we serve our country to the best possible advantage.

This mobilization of the entire profession should come from within the body itself, but every physician coming within the requirements of the service, as to age and physical fitness, should seriously consider this suggestion and not wait for complete mobilization but apply at once for a commission in the Medical Reserve Corps of the United States Army.

It is not only for the combatant forces that medical officers are required but for sanitation, hospital camps, cantonments and in other departments where the health and life of the forces are dependent upon the medical officer.

We have within the profession a sufficient number of doctors to fully meet the requirements of the Surgeon General's office whatever they might be, but to be of service, you must join the Medical Reserve Corps to enable you to meet the appeal which is now be-

ing made for a large and efficient Medical Reserve Corps upon which the Surgeon General may draw as requirements demand.

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### THE USE OF THE FACE MASK AND OTHER PRECAUTIONS AGAINST PNEUMONIA AND OTHER DISEASES SPREAD BY NASOPHARYNGEAL SECRETIONS.

The nasopharynx is the portal of entrance into, as well as exit from the body, of the germs of many important acute diseases. Diphtheria, scarlet fever, measles, epidemic meningitis, poliomyelitis and pneumonia are all spread by nasopharyngeal secretions, and are sometimes called "sputum-borne" diseases. These diseases are spread in this way not only by patients in the acute stages of the disease but also by carriers who harbor the germs in the nasopharynx for a longer or shorter time. Persons coming in close contact with such patients or carriers may take up the germ-laden droplets or nasal discharges, running the risk of falling sick, and whether stricken or not, of handing the germs on to others, perhaps more susceptible. In view of these considerations, the precautions, including the use of a simple protective face mask, recommended by Weaver<sup>1</sup> in this issue, should be adopted and conscientiously enforced, not only in hospitals, but also generally, since every case of sputum-borne infection is a potential source of new cases, and even an endless chain of new cases. The evidence presented by Weaver of the efficiency of the precautions which he describes for nurses and physicians is quite convincing — that is, there was less infectious disease in the nurses, and less cross infection in the patients. In other words, the spread of sputum-borne diseases was lessened. This was, of course, to have been expected because the measures described necessarily lessen the chance of infection for these diseases. The precautions used against diphtheria, measles,

scarlet fever, epidemic meningitis and poliomyelitis are also recommended for pneumonia because this is as much a sputum-borne disease as any. No physician familiar with the dangers of infectious nasopharyngeal secretions in pneumonia and the other diseases mentioned will care to run the risk of omitting any precautionary measure that obviously tends to lessen the danger for the attendant and to diminish the chances of spreading the infection by carriers. For this reason the advisability of wearing face masks by medical officers, nurses and noncommissioned medical attendants in base hospitals and isolation camps in large cantonments is worthy of careful consideration. The measure is so simple, and at the same time appears to be so thoroughly efficient, that the question arises whether the Medical Department should not make the use of this simple measure obligatory on the part of those in direct contact with the diseases mentioned. Personally, those tending the sick may feel that they are not susceptible to such diseases as measles, diphtheria, scarlet fever and similar infections — that is, those likely to attack children — but will they care to take any chances with pneumonia? — *Jour. A. M. A.*

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Your plans for dinner, Mrs. Housewife, are just as important in their way as General Haig's plans for a night attack. Haig aims to get the maximum of results with the minimum of material. He uses plenty, but he doesn't waste any. So should you. That's the way you and Haig will win this war.

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It is impossible that anything but benefit can come to the American family which signs the Food Administration Pledge.

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**IT IS NOT NECESSARY TO FORWARD YOUR APPLICATION BLANK FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY, TO THE SURGEON GENERAL. PRESENT IT, TOGETHER WITH THE OTHER PAPERS REQUIRED BY REGULATIONS, TO THE EXAMINING BOARD AT THE TIME YOU APPEAR FOR EXAMINATION.**

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1. Weaver, George H.: The Value of the Face Mask and Other Measures, *The Journal A. M. A.*, p. 76, January 12, 1918.

APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.  
Sir :

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....
4. When and where were you naturalized? (For applicants of alien birth only.).....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....
10. If either parent or brother or sister has died, state cause and age in each case :.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation : .....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc. : .....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates : .....
16. With what ancient or modern languages or branches of science are you acquainted?.....

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\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.



17. How many courses of lectures have you attended?..... Names of colleges and dates: .....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result: \* .....
20. Are you a member of any State medical society? If so, give its name: .....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service: .....
22. What clinical experience have you had in dispensary or private practice? .....
23. Have you paid particular attention to any specialty in medicine; if so, what branch? .....
24. What opportunities for instruction or practice in operative surgery have you had? .....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why): .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity: .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it: .....
28. What occupation, if any, have you followed other than that of student or practitioner? .....
29. What is your present post-office address? .....
30. What is your permanent residence? .....
31. (Signature of applicant.) .....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.

## OUR HONOR ROLL.

Our Honor Roll as published below now constitutes a grand total of one hundred and forty-four physicians. They are divided in the services as follows: Medical Corps—Lieutenant Colonel, 1; Medical Reserve Corps—Majors, 8; Captains, 25; 1st Lieutenants, 96; total, 130. United States Navy—Passed Assistant Surgeons, 2; Assistant Surgeons, 3; total, 5. National Guard United States (Fla.)—Majors, 3; Captain, 1; 1st Lieutenants, 5; total, 9. The list is gradually becoming complete; we urge all to help us maintain it in a thorough manner.

## MEDICAL CORPS, U. S. ARMY.

*Home Address.*

Lieut.-Colonel Joseph Y. Porter.....Key West

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 Captain Owen H. Kenan.....Palm Beach  
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 Captain William W. Mills.....Miami  
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 Captain M. B. Swift.....Orlando  
 Captain Harry F. Watt.....Ocala  
 1st Lieut. A. E. Acker.....Jacksonville  
 1st Lieut. Daniel M. Adams.....Panama City  
 1st Lieut. Allen M. Ames.....Pensacola  
 1st Lieut. C. A. Andrews.....Tampa  
 1st Lieut. Harold M. Beardall.....Orlando  
 1st Lieut. Henry P. Bevis.....Arcadia  
 1st Lieut. James H. Bickerstaff.....Pensacola  
 1st Lieut. Everard Blackshear.....Citra  
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 1st Lieut. Fay A. Cameron.....Tampa  
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 1st Lieut. Joseph H. Chiles.....Cleremont  
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 1st Lieut. Wallace P. Crigler.....Ocala  
 1st Lieut. T. G. Croft.....Jacksonville  
 1st Lieut. Clinton W. D'Alemberte.....Pensacola  
 1st Lieut. James S. Davidson.....Clearwater  
 1st Lieut. Kenneth McC. Davis.....Westbay  
 1st Lieut. Gaston Day.....Jacksonville  
 1st Lieut. L. B. Dickerson.....Clearwater  
 1st Lieut. George W. Dupree.....Blue Creek  
 1st Lieut. Lester J. Efrd.....Tampa  
 1st Lieut. William T. Elmore.....Gainesville  
 1st Lieut. Orin O. Feaster.....Mulberry  
 1st Lieut. Nacy L. Gachet.....Century  
 1st Lieut. Harry C. Galey.....Key West  
 1st Lieut. Julian Gammon.....Jacksonville  
 1st Lieut. Claude V. Gautier.....Passagrille  
 1st Lieut. Hugh St. C. Geiger.....Kissimmee  
 1st Lieut. H. M. Ginsberg.....Pensacola  
 1st Lieut. Paul Goss.....Mulberry  
 1st Lieut. O. F. Green.....Mayo  
 1st Lieut. John D. Griffin.....Lakeland  
 1st Lieut. J. H. Hall.....Sopchoppy  
 1st Lieut. John Halliday.....Tampa  
 1st Lieut. Drew R. Handley.....Jacksonville  
 1st Lieut. MacMiller Harrison.....Palmetto  
 1st Lieut. John R. Hereford.....Fort Dade  
 1st Lieut. Frank P. Hixon.....Pensacola  
 1st Lieut. John C. Holley.....Pace  
 1st Lieut. Samuel G. Hollingsworth.....Bradentown  
 1st Lieut. H. F. Horne.....Jacksonville  
 1st Lieut. Roy Howe.....Daytona  
 1st Lieut. A. L. Izlar.....Ocala  
 1st Lieut. Edward Jelks.....Jacksonville  
 1st Lieut. Charles L. Jennings.....Jacksonville  
 1st Lieut. Charles L. Kennon.....Jacksonville  
 1st Lieut. Alpheus C. Koon.....Jacksonville  
 1st Lieut. William J. Lancaster.....Tampa  
 1st Lieut. Richard Leffers.....Lakeland  
 1st Lieut. John P. Long.....Lake City  
 1st Lieut. John W. McClane.....St. Petersburg  
 1st Lieut. George S. McClellan.....Wellborn  
 1st Lieut. James R. McEachren.....Monticello  
 1st Lieut. Harry B. McEuen.....Quincy  
 1st Lieut. William G. McKay.....Jacksonville  
 1st Lieut. R. B. McLaws.....Tampa  
 1st Lieut. Earle H. McRae.....Tampa  
 1st Lieut. H. R. Mills.....Tampa  
 1st Lieut. George M. Mitchell.....Jacksonville  
 1st Lieut. Joseph A. Mixon.....Pensacola  
 1st Lieut. H. P. Newman.....Bartow  
 1st Lieut. John A. Newnham.....Cleremont  
 1st Lieut. John K. Norwood.....Jacksonville  
 1st Lieut. Bascom H. Palmer.....Tampa  
 1st Lieut. Henry E. Parnell.....Fort Myers  
 1st Lieut. Archie R. Parrott.....Jacksonville  
 1st Lieut. James L. Pennington.....Fountain  
 1st Lieut. J. O. Phillips.....Worthington Springs  
 1st Lieut. William H. Pickett.....Gainesville  
 1st Lieut. Marion E. Quina.....Pensacola  
 1st Lieut. Shaler A. Richardson.....Jacksonville  
 1st Lieut. Dwight M. Rivers.....Lake City  
 1st Lieut. E. T. Sellers.....Jacksonville

1st Lieut. George W. Sherouse .....	Campville
1st Lieut. E. E. Strickland .....	Miccosukie
1st Lieut. Baldwin S. Stutts .....	Port St. Joe
1st Lieut. G. C. Tillman .....	Gainesville
1st Lieut. W. J. Vinson .....	Tarpon Springs
1st Lieut. Adam C. Walkup .....	McIntosh
1st Lieut. Archie Watson .....	Live Oak
1st Lieut. B. L. Whitten .....	Fort Pierce
1st Lieut. John M. Whitfield .....	Malone
1st Lieut. William E. Whitlock .....	Fort White
1st Lieut. Charlton C. Whittle .....	Nocatee
1st Lieut. Daniel B. Williams .....	Lake City
1st Lieut. Albert H. Wilhienson .....	Jacksonville

#### THE NAVY.

Passed Assistant Surgeon W. P. Dey ..	Jacksonville
Assistant Surgeon Thomas S. Field ..	Jacksonville
Assistant Surgeon Boyd Gilbert .....	Pensacola
Passed Asst. Surgeon J. Knox Simpson,	Jacksonville
Assistant Surgeon D. C. Thompson .....	Pensacola

#### NATIONAL GUARD UNITED STATES (FLA.).

Major Lorin Green .....	Jacksonville
Major Ralph Green .....	Jacksonville
Major James H. Livingston .....	Jacksonville
Captain W. J. Buck .....	Gainesville
1st Lieut. Daniel C. Campbell .....	Marianna
1st Lieut. John R. Hawkins .....	Williston
1st Lieut. Z. V. Johnson .....	Milton
1st Lieut. Lucien B. Mitchell .....	Tampa
1st Lieut. J. M. Mitchell .....	Millville

### THE NEEDS OF THE MEDICAL SERVICE.

Under the above caption, Colonel R. E. Noble, M.C., U.S.A., presented before the last meeting of the Southern Medical Association, a most admirable paper, which convincingly answers the many questions asked of the department, and which have caused perplexing hours of thought with many doctors.

The communication appears in full in the December issue of the *Southern Medical Journal* and should be read by every doctor in this country.

In a previous paper by the same writer, presented prior to the time that the United States entered the world struggle, as in the above referred to communication, Col. Noble said: "On the medical profession rests a heavy responsibility, for with the medical profession rests the subject of medical preparedness."

This is a particularly impressive paragraph and pregnant with truth, and its meaning should sink deep into the heart of every doctor in America. What was a fact before

we entered the struggle is more than a fact now, since we have joined forces with our Allies in a world war, and which will only be terminated by the success of our arms.

We have not a sufficient number of medical officers to care for the combatant and other forces now in training. With the new draft soon to be called and the possibility of the raising of an army of between five and ten million, as has been authoritatively foreshadowed, we would repeat: "On the medical profession rests a heavy responsibility, for with the medical profession rests the subject of medical preparedness."

The responsibility of the medical profession of the United States and its importance in the successful outcome of the war can not be too forcibly impressed upon every doctor who is mentally and physically fit and within the age limit, and they are urged to offer their services now.

That the Surgeon General should have an immense corps of Medical Reserve Officers upon which to draw, enabling him to place the individual where he will be best fitted for the service is manifestly apparent. This will mean efficiency and by efficiency alone can the responsibility now resting upon the medical profession of this country be lessened.

Apply at once for a commission in the Medical Reserve Corps and thus relieve the responsibility which you owe to your country, your profession and yourself.

### REPORTING OF ACCIDENTS FROM LOCAL ANAESTHETICS.

To the Editor—The Committee on Therapeutic Research of the Council on Pharmacy and Chemistry of the American Medical Association has undertaken a study of the accidents following the clinical use of local anesthetics, especially those following ordinary therapeutic doses. It is hoped that this study may lead to a better understanding of the cause of such accidents, and consequently to methods of avoiding them, or, at least, of treating them successfully when they occur.



It is becoming apparent that several of the local anæsthetics, if not all of those in general use, are prone to cause death or symptoms of severe poisoning in a small percentage of those cases in which the dose used has been hitherto considered quite safe.

The infrequent occurrence of these accidents and their production by relatively small doses point to a peculiar hypersensitiveness on the part of those in whom the accidents occur. The data necessary for a study of these accidents are at present wholly insufficient, especially since the symptoms described in most of the cases are quite different from those commonly observed in animals even after the administration of toxic, but not fatal, doses.

Such accidents are seldom reported in detail in the medical literature, partly because physicians and dentists fear that they may be held to blame should they report them, partly, perhaps, because they have failed to appreciate the importance of the matter from the standpoint of the protection of the public.

It is evident that a broader view should prevail, and that physicians should be informed regarding the conditions under which such accidents occur in order that they may be avoided. It is also evident that the best protection against such unjust accusations, and the best means of preventing such accidents consist in the publication of careful detailed records when they have occurred, with the attending circumstances. These should be reported in the medical or dental journals when possible; but when, for any reason, this seems undesirable, a confidential report may be filed with Dr. R. A. Hatcher, 114 East Twenty-sixth street, New York City, who has been appointed by the committee to collect this information.

If desired, such reports will be considered strictly confidential so far as the name of the patient and that of the medical attendant are concerned, and such information will be used solely as a means of studying the problem of

toxicity of this class of agents, unless permission is given to use the name.

All available facts, both public and private, should be included in these reports, but the following data are especially to be desired in those cases in which more detailed reports can not be made:

The age, sex, and general history of the patient should be given in as great detail as possible. The state of the nervous systems appears to be of especial importance. The dosage employed should be stated as accurately as possible; also the concentration of the solution employed, the site of the injection (whether intramuscular, perineural or strictly subcutaneous), and whether applied to the mouth, nose, or other part of the body. The possibility of an injection having been made into a small vein during intramuscular injection or into the gums should be considered. In such cases the action begins almost at once, that is, within a few seconds.

The previous condition of the heart and respiration should be reported if possible; and, of course, the effects of the drug on the heart and respiration, as well as the duration of the symptoms, should be recorded. If antidotes are employed, their nature and dosage should be stated, together with the character and time of appearance of the effects induced by the antidotes. It is important to state whether antidotes were administered orally, or by subcutaneous, intramuscular or intravenous injection, and the concentration in which such antidotes were used.

While such detailed information, together with any other available data, are desirable, it is not to be understood that the inability to supply such details should prevent the publication of reports of poisoning, however meager the data, so long as accuracy is observed.

The committee urges on all anæsthetists, surgeons, physicians and dentists the making of such reports as a public duty; it asks that

they read this appeal with especial attention of the character of observations desired.

TORALD SOLLMANN, *Chairman*.

R. A. HATCHER, *Special Referee*.

*Therapeutic Research Committee of the Council on Pharmacy and Chemistry of the American Medical Association.*

### A STATE SOCIAL WELFARE PROGRAM.

A Social Welfare Program for the State of Florida has been published by the Russell Sage Foundation of New York City, being based upon a study made by Dr. Hastings H. Hart of that organization and Clarence L. Stonaker of the New Jersey State Charities Aid and Prison Reform Association. This report was prepared at the request of Governor Catts who had seen a report prepared by these gentlemen earlier in the year for the West Virginia Council for Defense; and it was upon his invitation that this report was made for the State of Florida.

The report contains forty-four pages of matter, topically arranged, and covers a number of activities within the State upon which suggestions and recommendations are made.

The report suggests the establishment of a State hospital in the eastern part of the State, on the cottage plan, for the immediate use of returned soldiers, crippled, convalescent, or insane; and that the construction of this new hospital should be so planned that it may be used after the war as a general hospital for the insane, which would relieve the overcrowded condition at the State institution in the western part of Florida.

The report speaks in praise of the State Agricultural Department in its activities—in developing the great drainage projects, the reclamation of waste land, the spread of diversified farming, and improved method of distribution. It highly commends the extension work of the State University and the College for Women. It also recognizes the value of the recent activities of the State

Sanitary Live Stock Board. All these, with the new work at the State Prison Farm, unite in a large program of food conservation.

Florida has been slow in developing her social institutions. This fact has been a disadvantage in the past, but it is now an advantage for the reason that the State has the opportunity in developing its future social work to avail itself of the experience of other States, which have spent millions in experiments. By observation and study Florida can take advantage of their successes and failures.

The plan of administration of the State correctional and charitable institutions by a board made up of executive State officers is very undesirable, but as this is a constitutional provision it can not be altered without an amendment to the constitution, which is generally a difficult matter to accomplish. It is suggested that a State board of control be established similar to the board which directs the activities of the educational institutions of the State.

Florida has made generous provision for public health service by the creation of a State Board of Health supported by a tax of half a mill. In recent years a considerable part of the income has been used in building elaborate headquarters in Jacksonville and offices with laboratories in other cities. Now that this is done, the funds of the board may be released for real health work. The report suggests that the board establish inspection of tenement houses in cities and insanitary homes in rural communities. The board should immediately undertake to develop a hospital program, either by establishing three or more general State hospitals or by the development of county hospitals in at least ten leading counties.

The report says: "We feel constrained to caution those in authority carefully to guard this great agency \* \* against \* \* infection with the destructive virus of the political spoils system. It deals with the life and death of little children and men and women. It would be a sad day for Florida

if ever the State Board of Health should become a political machine \* \*. The duty of guarding the State Board of Health rests with the Governor who appoints its members."

A detailed report is made of the State Hospital for the Insane at Chattahoochee, with recommendations. It commends the prison system in its new development of farm and road work, and expresses the hope that the leasing of prisoners to private corporations will soon be ended in the State.

It is very desirable that juvenile court methods shall be introduced, and probation officers appointed for every county in the State.

Florida ought to make immediate institutional provision for at least 500 feeble-minded persons, upon the colony plan. There should be established a State agency for the protection of neglected children, which should include the supervision of all private agencies dealing with dependent and neglected children.

The educational problem of the State is fairly well met in the reorganized higher institutions of learning, but there is not enough work done in the preparation of teachers for common schools. The normal departments in the several institutions should be strengthened, and there should be extension work throughout the State to supplement the work

done at the college centers, for the need is very great for a higher standard in the teaching force of the common schools. The State School fund is limited, and must be augmented either by raising the tax limit or by creating a fund from the leasing of reclaimed State land. The distribution of the school funds should be based upon the school attendance rather than the school census, as this would result in better attendance upon the schools. Public school management should be absolutely removed from the realm of partisan control, and to that end the county superintendents of schools should be appointed by the State Superintendent of Public Instruction, or a central board of education. A serious lack in the school system of Florida is the absence of a proper school attendance law. A short school year, with an inefficient teaching force, meagerly paid, with a yet shorter year and less compensation for the schools for colored children, offers a premium upon dependency, waywardness, delinquency, and eventually crime.

The county boards have sole authority to relieve temporary distress, and give aid to families in need. The practice of publishing the names of such beneficiaries as part of the proceedings of the board meetings should be abolished.

## Cancer Department

*"In the early treatment of cancer lies the hope of cure"*

AMERICAN SOCIETY FOR THE CONTROL OF CANCER

### A SWISS CANCER INVESTIGATION.

The following article which appeared in a recent issue of *The Lancet* will, we are sure, prove of special interest to all of our readers who are following the study of cancer statistics:

"The Council of the Swiss Association for Combating Malignant Disease has addressed a circular to the Swiss doctors calling attention to the conspicuously high incidence of

cancer in Switzerland and to the fact that nothing is yet known either as to the cause of the disease or the explanation of its special prevalence in that country. The council, therefore, asks for precise statistical and clinical information in regard to all fatal cases of cancer of the breast. Special notes are requested, first, of the influence of lactation, mastitis, or previous innocent tumors (fibro-adenoma, cysts) on the development



of cancerous growth, and, secondly, of the effect on prognosis of operation, Roentgen rays, or radium applications. This inquiry will be based on the death certificates sent in to the Statistical Department. Similar information is also requested in regard to the patients still living at the end of 1915 who had been under treatment for mammary cancer during the preceding five years. A modest honorarium of 2 francs is offered for each schedule thus filled in, and the association hopes to obtain statistical material which may lead to the formation of some useful opinion. Switzerland has, as is well known, the highest cancer death-rate in the world, although alone among civilized countries the rate is a diminishing one. Inspection of all dead bodies by a medical man is compulsory in Switzerland, and this may to some extent account for the highness of the death-rate in cancer. Any proposal to amplify the statistical information on cancer in that country is valuable and welcome, and the selection of mammary cancer for intensive study is a wise one. The frequency of operation, with its accompanying accuracy in pathological diagnosis, secures a firm objective basis for the data, and the points selected for the questionnaire are precise and well selected. The demarcation of urban, industrial, and pastoral communities in the population is definite and should enhance the value of the results obtained."

We have written to Prof. F. Dumont of Berne who is an active worker for the control of the disease in Switzerland, asking for copies of the circular and questionnaire, addressed to the Swiss doctors, which are referred to in *The Lancet's* article. In exchange we have forwarded copies of the blanks for reporting cancer cases which are furnished by our organization to the surgeons of America, as well as copies of special blanks prepared by the Society for the study of cancer statistics in hospitals and life insurance companies.

As far as we can judge the action of the Swiss investigation follows precisely our

own motive in the direction of securing statistics for compilation and study.

Complying with the request of the Society for the Cure of Cancer in Switzerland, of which Prof. Dr. Dumont is Vice-President, copies of all available publications of our Society have been forwarded, and the name of that organization has been placed on our special mailing list for all future literature as issued. Prof. Dr. Dumont showed special interest in the lecture syllabus on "The Control of Cancer" authorized by our Council for the use of qualified speakers engaged in educating the public.

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#### STATE QUOTAS OF BABIES TO BE SAVED DURING CHILDREN'S YEAR.

The Children's Bureau of the U. S. Department of Labor announced today the number of lives each State is asked to save in the campaign to save 100,000 babies and young children during Children's Year beginning April 6. Announcement of the purpose to wage such a campaign was made some time ago by the Children's Bureau and the Child-Welfare Department of the Woman's Committee of the Council of National Defense, and the response, which has surpassed all expectations, indicates that efforts to promote the health and welfare of children are to be more vigorous this year than ever before.

The saving of 100,000 lives of children under five is only one part of the big program for the welfare of 30,000,000 children under fifteen in the country. It is realized by all concerned that the standards of child protection must not be relaxed during war-time, and the United States is expected to profit by the experience of other warring countries, where the importance of safeguarding childhood is emphasized as never before.

The campaign to save 100,000 lives of babies and young children in the United States during the second year of the war is to be inaugurated by a National Weighing

and Measuring Test beginning April 6th, the anniversary of the declaration of war by this country. In announcing the quotas the Children's Bureau said:

"In order that each State may feel responsible for a definite number of lives to be saved, quotas have been assigned to the various States, the apportionment being made on the basis of the population under five according to the 1910 census. This of course can not take account of the varying death rates in the different States where death rates are known.

"In about half the States of the country, comprising nearly one-third the population, the registration of deaths was not sufficiently complete to warrant their inclusion in the registration area when the latest reports were published. The registration of births is seriously deficient in a still larger number of States. For that reason the apportionment of quotas of infant lives to be saved could not be made upon the basis of the infant mortality rate, which is based on the number of deaths under one year and the number of recorded births. Thus the only basis for the assignment of quotas uniformly applicable to all the States is the population as shown by the Federal census. As the effort for the hundred thousand lives applies to the specially hazardous period of life under five years of age, the quotas are calculated upon the basis of the population under five.

"In making the apportionment on this basis it was realized that a high mark is thus set for States in which the death rate among young children is already low. On the other hand, the mark set may be low for some States where the child death rate is excessively high. It does not appear to be possible to avoid some situations of this kind by any method of apportionment that could be devised with the data now at hand. If the registration of births and deaths were complete in all the States, an apportionment of quotas of the 100,000 lives to be saved by

the various States could be made upon a different basis."

Plans for the celebration of Children's Year, of which the saving of 100,000 lives is one feature, are being developed by the Children's Bureau in cooperation with the Child-Welfare Department of the Woman's Committee of the Council of National Defense. The safeguarding and protection of children is looked upon as a patriotic duty in view of the unavoidable wastage of human life incident to war. It is expected that the 5,000 or more local committees of the Child-Welfare Department of the Woman's Committee will be able to carry the campaign to every community in the United States. This is looked upon as essential to the success of the movement, for in the last analysis, every community must save its own babies if they are to be saved at all. State and Federal agencies, either official or voluntary, can make plans and offer suggestions but each community must bear its full share of responsibility in making the campaign a success.

The quotas assigned to the various States are given in the following table:

	<i>Population under five, 1910 census.</i>	<i>Quota of lives to be saved.</i>
Total .....	10,631,364	100,000
Maine .....	71,845	676
New Hampshire .....	39,581	372
Vermont .....	34,171	321
Massachusetts .....	328,886	3,094
Rhode Island .....	54,098	509
Connecticut .....	112,244	1,056
New York .....	898,927	8,455
New Jersey .....	266,942	2,511
Pennsylvania .....	884,270	8,318
Ohio .....	479,475	4,510
Indiana .....	275,524	2,592
Illinois .....	597,989	5,625
Michigan .....	298,554	2,808
Wisconsin .....	256,171	2,410
Minnesota .....	226,840	2,134
Iowa .....	236,063	2,220
Missouri .....	360,503	3,391
North Dakota .....	82,399	775
South Dakota .....	73,489	691
Nebraska .....	140,096	1,318
Kansas .....	191,519	1,802
Delaware .....	20,045	188
Maryland .....	137,714	1,295
District of Columbia....	26,669	251
Virginia .....	268,825	2,529
West Virginia .....	169,118	1,591
North Carolina .....	332,792	3,130
South Carolina .....	228,459	2,149
Georgia .....	376,641	3,543

	<i>Population under five, 1910 census.</i>	<i>Quota of lives to be saved.</i>
<b>Florida</b> .....	<b>96,956</b>	<b>912</b>
Kentucky .....	294,503	2,770
Tennessee .....	294,591	2,771
Alabama .....	311,716	2,932
Mississippi .....	259,661	2,442
Arkansas .....	230,701	2,170
Louisiana .....	224,069	2,108
Oklahoma .....	241,904	2,275
Texas .....	538,984	5,070
Montana .....	38,323	360
Idaho .....	40,444	380
Wyoming .....	15,331	144
Colorado .....	82,562	777
New Mexico .....	45,285	425
Arizona .....	24,778	233
Utah .....	52,698	496
Nevada .....	6,383	60
Washington .....	108,756	1,023
Oregon .....	60,211	566
California .....	193,659	1,822

### THE REHFUSS METHOD.

The so-called fractional method of gastric analysis advocated by Rehfuß has been found to have such advantages that it has been introduced in the Battle Creek Sanitarium, where test meals to the number of thousands are given each year. To the patients the new plan is vastly preferable. Indeed, the swallowing of what was often called "the garden hose" was attended in most cases by actual suffering and in many by severe pain. Under the fractional method, a very small tube is used. An oval tip, made of metal and perforated, makes the swallowing easy. Of course, it is inconvenient to have to sit for an hour and a half or two hours without removing the tube, but there is no real distress. The usual test meal of two slices of toast and a glass of water is given, at intervals of half an hour, a small specimen of the gastric juice, 10 or 16 c.c. is taken, until the acidity curve begins definitely to come down.

Under the old method, the practice was to take out all the gastric juice at the end of an hour. At Battle Creek, the period had been lengthened to an hour and a quarter because this was found to be the usual time of greatest acidity. A comparison of the two methods shows that the original plan was misleading in many instances. Under that

procedure, cases would be set down as normal if the acidity was shown to be at the usual percentage one hour after the meal. However, as the fractional method proves, many patients who have the right acidity at that minute, many have far too little or too much, before and after the hour has passed. By studying the complete cycle of digestion, an accurate diagnosis may be made.

### NEW AND NONOFFICIAL REMEDIES.

**ACETYSALICYLIC ACID — MERCK.** — A brand of acetylsalicylic acid complying with the New and Nonofficial Remedies standards. Acetylsalicylic acid is employed in rheumatic conditions, and especially as an analgesic and antipyretic in colds, neuralgias, etc.

**BARBITAL.**—**Fiethyl-Barbituric Acid**, first introduced under the name veronal. In small doses barbitol is a relatively safe hypnotic, but fatalities have followed its indiscriminate use. It is claimed to be useful in simple insomnia, as well as in that accompanying hysteria, neurasthenia and mental disturbances. From 0.3 to 1 gm. (5 to 15 grains), in hot water, tea or milk, or, if in wafers or capsules, followed by a cupful of some warm liquid.

**BARBITAL**—**ABBOTT.**—A brand of barbitol complying with the New and Nonofficial Remedies standards. The Abbott Laboratories, Chicago.

**BETANAPHTHYL SALICYLATE—CALCO.** — A brand of betanaphthyl salicylate complying with the New and Nonofficial Remedies standards. Betanaphthyl salicylate is believed to act as an intestinal antiseptic and, being excreted in the urine, to act in a similar way in the bladder. It is said to be useful in intestinal fermentations, catarrh of the bladder, particularly gonorrheal cystitis, rheumatism, etc. The Calco Chemical Co., Boundbrook, N. J.

**CHLORCOSANE.** — A liquid obtained by chlorinating solid paraffin. It contains about



50 per cent of chlorin in stable combination. Chlorcosane is used as a solvent for dichloramine-T; with it solutions containing as much as 8 per cent may be prepared. When used in a hand atomizer, chlorcosane solutions of dichloramine-T may be made less viscous by the addition of 10 per cent of carbon tetrachloride. The Abbott Laboratories, Chicago.

**CHLORAZENE SURGICAL POWDER.**—An impalpable powder composed of chlorazene, 1 per cent; zinc stearate, 10 per cent, and sodium stearate, 89 per cent. Chlorazene Surgical Powder is absorbent, slightly astringent, and forms a closely adherent film when applied to the skin. It may be dusted freely over denuded or abraded areas, cuts, wounds, and skin eruptions. The Abbott Laboratories, Chicago. (*Jour. A. M. A.*, Feb. 16, 1918, p. 459.)

**DICHLORAMINE-T (CALCO).**—**PARATOLUENESULPHONEDICHLORAMIDE.**—This is said to act much like Chloramine-T, but is capable of being used in a solution of eucalyptol and liquid petrolatum, thus securing the gradual and sustained antiseptic action. Like Chloramine-T, dichloramine-T (Calco) is said to act essentially like the hypochlorites, but to be less irritating to the tissues. Dichloramine-T (Calco) is said to be useful in the prevention and treatment of diseases of the nose and throat. It has been used with success as an application to wounds, dissolved in chlorinated eucalyptol and chlorinated paraffin oil. Manufactured by the Calco Chemical Co., Boundbrook, N. J.

**HALAZONE-CALCO.**—**PARASULPHONEDICHLORAMIDOBENZOIC ACID.**—It is said to act like chlorine and to have the advantage of being stable in solid form. In the presence of alkali carbonate, borate and phosphate it is reported that halazone in the proportion of from 1:200,000 to 1:500,000 sterilizes polluted water. Manufactured by the Calco Chemical Co., Boundbrook, N. J.

**MERCURY BENZOATE—MERCK.**—A brand of mercuric benzoate complying with the New and Nonofficial Remedies standards.

Mercuric benzoate has the properties of mercuric chloride. It has been said to be useful for hypodermic use and in gonorrhea. Merck and Company, New York.

**STERILE SOLUTION COAGULEN-CIBA (3 PER CENT) 1.5 C.C. AMPOULES.**—Each ampule contains 1.5 c.c. of a 3 per cent solution of coagulen-Ciba. A. Klipstein and Co., New York City.

**STERILE SOLUTION COAGULEN-CIBA (3 PER CENT) 20 C.C. AMPOULES.**—Each ampule contains 20 c.c. of a 3 per cent solution of coagulen-Ciba. A. Klipstein and Co., New York City.

**TABLETS COAGULEN 0.5 GM.**—Each compressed tablet contains 0.5 gm. coagulen-Ciba and 0.46 gm. sodium chloride. A. Klipstein and Co., New York City.

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Millions of European farmers have left their fields to fight for the safety of America and the world. Those fields therefore haven't been producing much. Ours have. Europe's food has got to come from somewhere. America is the place. It's little enough to ask the individual American to conserve what our fields produce, so our European brethren can have plenty and keep up the fight. Save your bit!

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The women and children of our allies in Europe know hunger in its most bitter forms. There is no need that the women and children of America should be hungry. They may eat abundantly—but wisely and without waste—and still save the women and children of our allies from the extremes of hunger. That's why every woman is urged to enroll as a member of the Food Administration.

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The boy you cheered when he marched away will stand knee deep in trench mud; he will face poison gas and deadly flame. He will endure all the terrors of modern battle. That's his bit. Your bit, perhaps, is to save one slice of bread a day in order that he may not fight in vain.

## Publisher's Notes

### DICHLORAMINE-T.

A new antiseptic which is attracting much attention and which has recently been introduced by Dr. H. D. Dakin of the Herter Laboratory, New York, is Toluene-parasulphondichloramine, or, as it is commonly known, Dichloramine-T. This antiseptic is used in oil solution, either as a spray or as a direct application.

The Dichloramine-T is dissolved in a Chlorinated Eucalyptol solution, then diluted to proper strength (from 2 to  $1\frac{1}{2}$  per cent) with Chlorinated Paraffin Oil.

In a paper published in the July 1 number of *The Journal of the American Medical Association*, Dakin, Lee, Sweet, Hendrix, and LeConte tell of the use of this substance in 160 cases of infected wounds. They found that when sprayed upon these wounds or poured into them the length of time required for healing, compared to the usual methods of treatment, was reduced to one-third. The wounds were cured in one-sixth less time than by the celebrated Carrel irrigation method; also, the expense of dressings and nursing, and the technical skill required in the application, was much less than by the irrigation method. It has also been found that Dichloramine-T, when sprayed into the nose and throat, is an effective method of treating diphtheria and meningococcus carriers.

Dichloramine-T contains about 29 per cent of chlorine, and, as already indicated, can be used in very high concentration. It is also possible to apply to infected tissue solutions from 20 to 30 times as great as is possible with the Dakin-Carrel hypochlorite solution.

This substance has been placed upon the market by The Abbott Laboratories, who also supply the Chlorinated Eucalyptol and Chlorinated Paraffin Oil prepared ready for use, according to the method described by Doctor Dakin. Dichloramine-T promises to

be a worthy partner of Chlorazene, the water-soluble antiseptic also devised by Dakin, which was placed upon the market by The Abbott Laboratories and which is proving such a phenomenal success.

Physicians are advised to familiarize themselves with these two antiseptics. Literature and prices will be sent on request to The Abbott Laboratories, Chicago.

---

### AMERICAN VERONAL.

In the Trading with the Enemy Act recently passed by Congress, provision was made for the licensing of American manufacturers by the Federal Trade Commission to produce articles and substances patented in this country by enemy aliens. Already a number of chemical manufacturers have taken advantage of this provision, among them The Abbott Laboratories of Chicago, which has applied for and secured a license for the manufacture of Veronal, which, however, will be known hereafter by the name Barbitol. This is the official name given it by the Federal Trade Commission, and this name must be used as the principal title by every firm manufacturing it under license from our Government.

The Abbott Laboratories have already begun the manufacture of Barbitol (formerly known as Veronal), and we understand that in short time it expects to have an abundant supply of this well-known hypnotic, and that it will be made generally available through the trade. The quality of the product is guaranteed. Indeed, before a license is granted for the manufacture of any of these patented synthetics in the United States, the product must be submitted to rigid investigation at the hands of a chemist designated by the Federal Trade Commission. In this way Americans are assured of supplies of the American-made products at reasonable

prices, and the manufacture of fine American chemicals is given the stimulus which it requires.

Those interested are urged to communicate with The Abbott Laboratories, Chicago.

---

America is requested to save fats to make the German ranks thin. That will do it and you can help. Use a third of an ounce less every day. Every square meal you save for the boys in the trenches and their folks back home brings Kaiserism that much nearer moral starvation.

---

If American women fail to do their part in this war, it will be their first failure. President Wilson says the most vital part they can play is to enroll as members of the Food Administration and "cheerfully accept its direction and advice."

---

Germany is striving to fasten her system on Europe and the world, through starvation. You can help thwart Germany's ambition by enrolling as an active member of the

Food Administration. Don't be partners of the Prussians.

---

If you think it better to whip Germany in Europe, rather than fight her here, help feed our allies and keep them in the fight. Sign up as a member of the Food Administration.

---

Millions of women and children in Europe — our allies — can be saved from bitter hunger if you will eat one slice less of wheat bread each day.

---

If you want Germany to win this war, waste food—use up the food needed by those who are fighting her.

---

And just as you say that you will not change your style of living a starving baby dies in France.

---

That pound of wheat flour *you* save every week will weigh very heavily on the Kaiser's mind.



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THE JOURNAL  
— OF THE —  
Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV      St. Augustine and Jacksonville, Fla., March, 1918      Yearly Subscription, \$1.50  
No. 9      Single Copy, 15c.

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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at St. Augustine, Fla., Oct. 23, 1914

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, March, 1918

Number 9

## ORIGINAL ARTICLES

### MEDICAL PREPAREDNESS IN THE GREAT DRIVE OF DEMOCRACY.\*

JOSEPH COLT BLOODGOOD, M. D.,  
*Major, Medical Reserve Corps, U. S. Army,*  
*Chairman Committee on Preparedness,*  
*Southern Medical Association,*  
Baltimore, Md.

The speakers who have preceded me are veterans of the regular corps of the British, French and United States Armies. The "R" in M. R. C. really stands for "raw recruit," and this audience will have the enjoyable opportunity of listening to a combat of words between veterans and a raw recruit.

The medical profession of this country is urged by this raw recruit to listen to the messages from France.

The cosmic message from those facing death is daily published. The Russian people have given 6,000,000 of their soldiers, because of inferior equipment with modern guns, and prevented France from being crushed while Great Britain and her colonies gathered their strength. Italy has helped by pushing the Austrians until Russia's internal conflict released Germans for the blow at Italy.

France and Great Britain are more than holding on the Western front. They are driving Germany, protecting us until we have joined with all our forces.

You have heard Colonel Derclé's dramatic remark that in the beginning of the war France intimated to Germany to stop, and they stopped. You heard Colonel Goodwin describe how the thin line held in the battle of the Marne.

These nations have fought out battles for three years and more. Our time has come. The raw recruit who speaks simply transmits messages from our Allies and from comrades in our Army in Europe.

The entire Nation is called now. The test of democracy is at hand.

Never before has the medical profession been given such an opportunity to set the high example of patriotism and service.

The time has passed for any individual member of the medical profession of this country to decide for himself as to whether his services are required, or where. All must volunteer. *We can and must draft ourselves.*

### *Medical Preparedness.*

At home, it should be chiefly preventive medicine and sanitation. When our Army is in France, or elsewhere, the great medical problem is surgery.

At home, Federal, state, city and county health departments and the medical departments of the industries must combine and co-ordinate their activities to protect the entire population and all the industrial workers from disease, and so release more physicians for the Army.

If these health departments are given the means and the authority, the number of cases of disease will be so greatly reduced that many physicians and surgeons would have little or nothing to do, and if there were no war demanding their services, they would be forced into other occupations, anyway.

In the Army, sanitation and preventive medicine is largely in control of everything. Even venereal diseases and alcohol can be, and are, controlled in those places where public sentiment and civic authority permit the enforcement of existing regulations for

\*Address, Public Session, Southern Medical Association, Eleventh Annual Meeting, Memphis, Tenn., Nov. 12-15, 1917. Originally published in *Southern Medical Journal*.



the zones outside the camps—for example, at Camp Greenleaf, Fort Oglethorpe, Ga.

At the front the great as yet unsolved problems in preventive medicine have to do with the extermination of body vermin and rats in the trenches.

The great medical problem in this war is wound treatment.

Victory can not be won without wounds. These wounds must be healed. When a soldier falls, his life, his present and future comfort, happiness and usefulness, are in the hands of the medical and nursing professions.

The wounded soldier must be so treated that he either returns to the front fit to fight or home fit to work.

Peace surgery must give way to war surgery.

If any one must suffer, it must not be the man fighting our battles and preserving the life of the Nation.

Soldiers in immense numbers are required to win this war, and we must have specially trained physicians, surgeons and nurses to care for them.

Should the medical profession volunteer *en masse* and so draft themselves, it will be enforcing an example on the industrial workers who are asked to forge the guns and build the ships.

Ships are essential for the transportation of the republic's great Army and all the things that must accompany this Army. These men must not be allowed to land in France without guns of sufficient caliber to protect them, and without numberless eyes in the air to guide the Army and its guns.

Ruthless war is a threatening world disease. When ruthless war wins, liberty and all that liberty-loving people cherish for themselves and posterity, and for the world is replaced by slavery.

Centuries of effort to give liberty to the world are lost.

Oppressed peoples must again begin the long struggle.

Never before has one group of people faced such a catastrophe of total destruction by another group.

Which type of people shall survive? The result is practically in the hands of liberty loving free America.

### *Medico-Military Preparedness.*

In the standardization of hospitals about to be begun in the United States the question to be asked and solved is: What is best for the patient? This problem can not be solved unless we have a sufficient record in the hospitals and a follow-up system.

In war efficiency the question is: What is best for the soldier?

In the special training of a civil physician or surgeon for military duty, he first must have a degree from a recognized medical school. Next he must pass the physical test. Then he is a candidate for a commission.

Every officer commissioned in the Medical Reserve Corps should start with this physical fitness.

The first requirement, however, is a spirit generated by belief in the cause of the war and the urgent necessity of the hour. This spirit leads to the volunteering for service.

The commissioned candidate is now ready for the special training in his military and medico-military duty.

At the outset there are two large groups or classes:

One group especially trained for duty in the zone of advance from a regimental medical officer to the evacuation hospital. In this group the age should be forty-five years and less. The physical requirements are greater. The second group is trained for the evacuation, base and home hospitals. Here the age of many may be between forty-five and fifty-five. The physical requirements are less.

In the zone of advance purely military and medico-military requirements are greater with the regimental officer and least in the evacuation hospital, while purely clinical requirements are least on the firing line and grow greater and should be of the highest degree in the evacuation hospital.

Each civil physician or surgeon who enters the Medical Reserve Corps starts with a varying degree of purely clinical knowledge and experience. Few, if any, have had purely military training.

Every candidate, if possible, should have a certain amount of special training in the military and medico-military duties of the Army. Those finally selected for the zone of advance receive further training in their special military, medico-military and purely clinical requirements. Those selected for duty in the evacuation hospitals and the zone of the interior to the home hospitals should have further intensive instruction in purely clinical work, which this war has demonstrated to be different, in sanitation, medicine and surgery from the requirements in practice at home in time of peace.

Much of this training in military, medico-military and clinical work in sanitation, medicine and surgery should be done in this country in the Officers' Training Camps, in the great cantonments and in the other training camps, and in the special post-graduate schools which have been established.

The Officers' Training Camps have been running to their full capacity at Forts Riley, Benjamin Harrison and Oglethorpe. The Training Camp Greenleaf at Fort Oglethorpe will probably be greatly enlarged.

Special postgraduate courses have been established in orthopedic surgery, radiology, neurological surgery, oral plastic surgery, fractures, the Carrel-Dakin method of treatment of infected wounds, the treatment with chloramine-T; a school of hygiene and sanitation has been established at Fort Oglethorpe; special laboratory courses are being given.

These special courses in purely clinical work in the different specialties have not only been organized in the medical departments of great universities, but in connection with the base hospitals in all cantonments. The Surgeon-Generals of the Army, Navy and Public Health Service all recognize this necessity. No member of the Medical Reserve Corps should for a moment conclude—

no matter how high his position in the surgical world—that he is ready to meet the purely clinical problems of military medicine and surgery without some intensive instruction in the special problems.

Military and medico-military training begin a Medical Officers' Training Camp. Every candidate should at least apply for this training. The training is continued in other camps. Some officers unfortunately must get it there without the preliminary course in the Medical Officers' Training Camps.

### *The Problems of War Surgery and Medicine.*

From the firing line to the home hospital there are at least four important stages, each with its special problems.

In the first place—on the firing line—the wounded are collected and receive a primary dressing and a primary fixation. The problems here are of efficient, rapid fixation to allow transportation on a stretcher. This is a combined military and clinical problem.

The second stage is one of transportation and the problem is chiefly military.

The third stage is the casualty hospital, and the problem is wound treatment.

The fourth stage is the base and the home hospital, and the problem is chiefly reconstruction and reeducation.

On the firing line there may not be much to be done beyond the primary dressing and the fixation, but what little should be done must be done by the regimental surgeon and medical corps is the foundation of a surgical treatment which ultimately makes the man return to the front fit to fight again or return home fit to work.

There is no agreement as to the value of an antiseptic in the primary dressing. It may be of value in wounds of lesser degree, but in the huge shell wounds at the present time it seems useless and a waste of precious minutes to attempt any disinfection. The wound should be simply covered with gauze.

The most important and difficult procedure is the primary fixation in splints or on

a stretcher for transportation. In view of the number of the wounded this primary fixation must be accomplished with great efficiency, but rapidly. The method of fixation with extension on the Army stretcher without splints appeals to me as the best. This will be published shortly in the *Military Surgeon*.

However, we should not cease to dream or stop in our search for a method of disinfecting the huge shell wound at the primary dressing. If we could find an antiseptic or a serum which would prolong the stage of contamination and put off the stage of infection, it would be an epoch-making discovery.

All agree that the best results are obtained when a wounded soldier is brought in contact with a well-trained surgical team in a fully equipped hospital in the best condition and in the shortest space of time. I am emphasizing the *best condition* and the *shortest space of time*.

The best condition is in the control of the regimental surgeon and his enlisted medical corps men. It depends upon the rapid collection of the wounded and the rapid and efficient primary fixation in splints or on the stretcher.

The shortest space of time is in the hands of the ambulance company. This transportation should be made with the least number of transfers and, if possible, with no redressing, no change of the splints, and no change from the stretcher. During transportation, shock, if possible, should be prevented or treated.

The majority of wounded should be transported directly from the regimental aid post to the evacuation hospital. The problem of selecting the lesser wounded who can be treated at dressing stations between the firing line and evacuation hospital is not a difficult one.

All agree that the majority of wounded soldiers in this war should be operated upon in a well-equipped hospital under anesthesia within eight hours whenever possible. This hospital as a rule can be placed from six to eight miles in the rear.

In trench warfare, when the firing line is more or less stationary, this hospital six or eight miles to the rear becomes a stationary hospital. It may then be called a base or evacuation hospital. As a rule it is the latter. However, when the firing line advances rapidly, these huge stationary hospitals can not be moved with the same rapidity, and for this reason we must be prepared with a mobile hospital which can keep within six or eight miles in the rear and which is equipped with all that is necessary for this primary operation.

In this war the field hospital which is mobile will have little to do except in the care of minor wounds, if the firing line is stationary; but if the firing line advances rapidly, it will have much to do and its equipment will have to be changed. Our present evacuation hospital was not designed for this primary operation, nor for the after-care of a large number of patients.

If the firing line is stationary this evacuation hospital will have to be enlarged to meet the demands, and as the firing line advances the evacuation hospital should be ready with its automobiles to become on twenty-four hours' notice a large, mobile operating unit.

All authorities agree that in the great majority of cases, when the wounded soldiers reach the evacuation hospital in eight hours or less, and the character of the wound allows, the wound should be excised not only to remove the blood clot and foreign body, but to cut out with the knife, as you would in malignant disease, all devitalized tissue. Then the wound may be closed with a large probability of healing.

This requirement places huge responsibilities and demands upon the regimental medical corps and upon the ambulance transportation service—largely a military problem. The excision of such a wound places upon the surgical team in the evacuation hospital a new problem. The number of wounded may be great, the character of each wound different. Not only must there be surgical technique and skill, but surgical judgment.



To facilitate the complete excision of such an irregular wound, some British surgeons stain the surface with brilliant green; others char with the cautery. All agree, however, that no surgeon should depend upon an antiseptic alone. The devitalized tissue must be excised.

When the wounded soldier fails to reach the evacuation hospital in time and the wound has passed from the stage of contamination to the stage of infection, the wound can not be closed. There also seems to be some difference of opinion as to whether the wound in the stage of infection should be excised. The majority favor thorough cleansing and removal of all foreign bodies and blood clots. In other cases the wounded soldier arrives within the time and the wound in the stage of contamination, but on account of its extent and character the devitalized tissue can not all be excised. These wounds must be left open. However, as to the treatment of the open wound there is a wide disagreement.

Two methods of treatment of the open wound are being intensely studied and advocated in this country, one, the Carrel-Dakin; the other the dichloramine-T.

The majority of the opponents of the Carrel method do not question the scientific precision of its technique nor the accuracy and brilliancy of its results. They claim, however, that this technique can only be followed successfully in a stationary hospital with a large personnel, and that it is difficult to teach large numbers of surgeons the details of this method. They claim also that it is more expensive not only in personnel, but in material. They call attention to the difficulty not only of placing the tubes properly, but keeping them patent, and the difficulty of preparing and keeping the hypochlorite solution at effective strength.

In Philadelphia, at the Pennsylvania and other hospitals, the treatment of open wounds by the chloramine-T method has been splendidly worked out in dispensary and ward practice. The motion picture lecture which is being delivered in this country

by Captain Furness and Lieutenant Lee is a marvelously pictured story. The men in this group are playing the game fairly and admit that it was the Carrel-Dakin method that led to this.

The technique which they have developed in the excision of the wound and in the re-dressing of the wound ranks with Carrel's. The only difference is in the application of the antiseptic. The open wound before and after its excision and at the daily re-dressings is sprayed and sponged with the dichloramine-T, the active principle of which is chlorine in eucalyptus oil. It differs from the Carrel method in the elimination of all drainage tubes and the twenty-four-hourly application of the antiseptic instead of the two-hourly.

The test of these treatments will not be in the lesser wounds of the type usually seen in industrial practice. As a matter of fact, the results without dichloramine-T and without the Carrel-Dakin have been uniformly good in these lesser wounds of industrial practice, when surgical skill, technique and judgment were good. But the shell wounds of this war are of a different type and Carrel has made a great contribution to their treatment. It is true that we have reports from France that dichloramine-T is accomplishing excellent results.

The lesson, however, which we must learn, and which was recently brought to us by Sir Moynihan and Major Crile, is that the surgeon must not depend solely upon any yet known antiseptic, but must be convinced that their results will depend upon aseptic technique, rapid skillful technique, surgical judgment, resourcefulness, constant attention to detail at the operation, and eternal vigilance in the after-treatment. The majority of surgeons, however, feel that some antiseptic is an essential part of the wound treatment at the primary operation and in the subsequent dressings of the open wound.

In all surgical diseases the interval of time between the onset of the local condition and its operative treatment is the first essential

factor in the cure. In this war many wounded soldiers will not reach the evacuation hospital within eight hours with wounds still in the stage of contamination only, and many of those who do will have wounds that can not be completely excised and closed. Therefore, there is required a treatment for the open wound and as far as my personal observation goes I do not as yet know of a substitute for the Carrel-Dakin method.

It is my personal opinion that no surgeon in this country, no matter what his position or standing, has the right to criticise the Carrel-Dakin method unless he has, through painstaking investigation and experience, devised a substitute. Such men as these can fairly be compared with those in this country who in one way or another obstruct our preparation for war and have no substitute to offer which will bring about a peace with victory.

The work of the group in Philadelphia with dichloramine-T should be welcomed and encouraged. The Surgeon-General has recognized it, as he has the Carrel method, by sending Medical Reserve Corps officers to both places for special instruction. Other clinics in this country should follow the example of the Philadelphia group and immediately start in wards and dispensaries an investigation, either comparative of these two methods or of a new one.

The surgical departments of the great industries should follow the example of Sherman, of Pittsburg, and Nolan, of Birmingham. The industries with the large number of accidental wounds are in the best position to start at once a thorough and scientific research into the problems of wound treatment.

The fourth zone or stage begins at the evacuation hospital and extends to the home hospital. When the wounded soldier can not be returned to the firing line fit to fight he should be returned home fit to work. The great problem here is one of reconstruction and reeducation. It is largely an orthopedic problem. But orthopedic principles should

be known and followed by the regimental surgeon in his primary fixation in splints or on the stretcher. Throughout the treatment the alignment of the broken bones, the proper position of the injured extremity, should be constantly maintained. From the beginning muscle, tendon, joint and nerve function should be maintained and restored as rapidly as possible. Reconstruction can be made a much less difficult problem, if surgery is good from the onset. The larger problems are orthopedic and wound treatment. Undoubtedly this war will show a tremendous change for improvement when experienced and well-trained specialists have charge of the head, chest and abdominal wounds at the primary operation.

All agree that after the primary operation there must be a period of rest in bed before there is a second transportation.

In military medicine and surgery one group of medical men will have chiefly military and administrative functions; another group of specialists and assistants will be chiefly occupied with purely clinical work; a third group, especially in the zone of advance, will have combined military and clinical duties. All must have a certain amount of general training in the clinical aspects; others are further and specially trained for the more difficult duties of military administration and supervision and for the greater demands of clinical responsibility in surgery, sanitation and medicine. There must be overlapping, and there will be failure if there is not co-ordination, team work and *esprit de corps*. The medical profession of this country must realize its responsibilities. The winning of the war depends upon its combined and co-ordinated action as much as upon any other department of the Army.

Now is the time to volunteer, to find out whether you are physically fit, whether you have the requirements, and whether your services are needed most at home or with the Army. All who volunteer their services, whether accepted and commissioned for duty or not, should receive some insignia of honor.

## WHAT THE WAR HAS DONE FOR MEDICINE.

SAMUEL W. LAMBERT, M. D.,

*Dean of the College of Physicians and Surgeons, Columbia University.*

The great war has presented to the world a new form of community life, with a new combination of the various elements which are to be found in every concentration of the populations of Western countries.

This war is unlike any previous war in that the old idea of campaigns with armies fighting battles and moving over large districts of territory was true in Belgium and France only for the first few weeks of the conflict. Such a conception has been realized more in the distant battlefields of Asia and Eastern Europe. The majority of the troops engaged on the West front have settled down to a permanent location and have continued more or less fixed in position for more than three years while they carry on their daily and nightly tasks of combat in what is known as trench warfare.

This war of 1914-1918 has developed, therefore, a community which has a population exclusively male, densely concentrated into habitations of the rudest structure, without modern facilities for sanitation, for ordinary cleanliness or for the housekeeping needs of the poorest dwellers in modern cities. The inhabitants of these "towns" are absolutely non-supporting and chiefly employed in killing with rifles, bombs and machine guns their nearest neighbors, or in protecting themselves from the like desire of their neighbors to "do" them first.

This population is a shifting one so far as the individuals are concerned, and it must be supplied with every necessity of life and with the munition supplies, as well, to carry on its chief occupation. These trench towns consume in proportion to their population a vast amount of supplies, and the inhabitants live a life entirely different from that of any community previously known in times of peace.

Such a community has developed new medical problems and has exaggerated some older ones already well known to the Army Medical Departments of all nations. The modern weapons with their high explosives and rapid fire and the inhumanities of asphyxiating gases and liquid fire have produced surgical conditions which are extremely infrequent as complications of the accidents of civil life. The habit of continuous warfare also has compelled the relief squads to delay their merciful tasks, and there results a high percentage of neglected infection and of the severer forms of blood poisoning and gangrene which modern aseptic surgery had eliminated from the experience of hospital practice.

At the beginning of the war an appreciable number of the troops had not been protected by the modern methods of vaccination against typhoid. That disease, and more particularly the closely allied condition, paratyphoid, were very prevalent. At the present time both diseases have been controlled to a large extent by a full application of the methods which were developed and applied first in the Army of the United States. At the present time, owing to the perverse influence of the so-called "antivivisectionists" in England, this form of preventive inoculation is only voluntary in the English Army. Nevertheless, nearly all the Tommies request it because its good effects have been demonstrated so conclusively even to the enlisted man. The latest development of the war is an earnest endeavor to apply the same preventive measure to control the various forms of pneumonia which has become a real menace to the troops wherever they are concentrated in large numbers.

The war has necessitated the formulation of methods to control diseases communicated by water. This has been done and dysentery, one of the oldest foes of armies, has been made less prevalent than in former wars. The present-day army physician must do more on these lines, however. He must



discover by quick action any contamination of wells and other supplies of drinking water from the addition of dead animals, sewage and even of mineral poisons such as arsenic whenever the allies advance in the territory lately occupied by the modern Huns.

The war has emphasized the importance of the group of diseases which are transmitted by the bite of vermin. One of these known as "spotted typhus" is caused by the body louse and is normally found in South-eastern Europe. It has been controlled by a rigid application of sanitary rules and by inoculation. Another disease of this group is known as Trench Fever, and has been discovered and introduced into Western Europe by the war, probably from the Orient. It is a short, very debilitating fever of low mortality, but which incapacitates its victims for an appreciable period. The medical staffs have controlled the ravages and negatived the military advantages which the German Military Staff expected to gain from the illegitimate use of large quantities of irritating gases. This was done by the application of properly constructed masks, although a number of casualties and substantial gains were made at the first attempt to advance in this manner.

The greatest additions to the antiseptic treatment of wounds have come from the chemical studies of Dr. Dakin, who has applied in various ways the properties of chlorine preparations to the disinfection of the wounds of this war. The problem which Dr. Dakin solved was to discover strong antiseptics which were able to destroy microbes without damaging normal tissues. Dr. Alexis Carrel developed a method of using the antiseptics of Dr. Dakin in the severely infected wounds which came to his hospital on the French front. His method consists of putting into the wounded tissues a system of multiple tubes and keeping the wound constantly washed with the antiseptic solution. The progress of the wound is watched by a daily bacteriological examination, and as soon as it is germ-free it is closed

and healing is quite prompt if the observations have been done in a precise manner.

The war has developed two large groups of cripples, one including those who have been maimed by the loss of hands, of arms of legs, or eyesight and in other physical ways. A great endeavor has begun to re-educate these men and to fit them for new trades and for a useful and self-supporting life. Many of this group of men can be taught to do work equally effective to that of their prebellum activities, although in a totally different line of endeavor. The second group of cripples are those who suffer from functional disturbances of the central nervous system. These cases present paralyzes and other disturbances of locomotion which are purely hysterical, or they show mental disorders which are also functional but which simulate true insanity in any of its manifold varieties. One of the most characteristic cases is that known as "shell shock," which is directly attributed to the sudden and unexpected exposure to the vibration and noise of the discharge of high explosives in a person overtired by physical work and overwrought by mental fatigue. A great success has been achieved by systems of nerve and muscle education, especially in French institutions devoted to this work. Many of the sufferers from these functional disturbances of the nervous system have been returned to a useful civil life, and some have rejoined the fighting ranks.

The effect of the war on medical education has been very striking.

The war has taken away all the surplusage from medical teaching staffs—particularly the surgical branches—and has rendered a complete medical education increasingly difficult. The College of Physicians and Surgeons, Columbia University, has lost probably more than a fourth of its force of instructors; in surgery about a third. The effect on civil hospitals has been equally startling. The attending staffs have been depleted in equal ratio with the staffs of the medical colleges. Hospital internes have

accepted service after the one year of training required by law for the Army and Navy. Because of their enthusiasm they have not waited to finish the two years usually required by most hospitals in this part of the country. There has been a tremendous upsetting of routine and personnel. Probably more than one-half of the internes have been lost to their hospitals. Many hospitals have reduced the term of service to one year.

To meet this deficit of men, the largest medical schools of New York City have put new speed into their instruction by omitting the usual vacation between the third and fourth years, and will graduate students in February instead of June. Columbia, New York University and Fordham have made this change.

At the same time, by intensive training and by clinging tenaciously to high standards, the medical schools are resolved, as well as confident, that the war shall not make the coming generation of physicians less well trained. When the score is added, it will be found that the war has done much to advance medicine along particular lines and that medicine has done much to advance the war.

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## WHAT IS NIGHTMARE OR PAVOR NOCTURNUS?

C. C. RUTER, M. D.,

Madison, Fla.

This is a condition usually referred to childhood, but to my certain knowledge by no means confined to children. The worst cases I have seen have been in old people. I have been studying this condition and searching all the medical literature I could find, but so far can find little or nothing concerning it. Forcheimer says the cause is increased cerebral irritability terminating in a bad dream, and at the termination of unconsciousness the attack is ended. I think his description of the condition is far from satisfactory. I have had very intelligent adult patients tell me that they were not unconscious, but that they could hear and know

all that was said and all that was going on about them; that they could talk, and when someone would come to them, that they would ask them to shake them or do something to bring them from under the seizure. They tell me that they are sometimes taken with a dream, but more often they find themselves seized while asleep with this very mysterious condition called nightmare. Again, I ask, What is it? Some people seem to think the heart stops; it does not. Others declare they smother and that respiration ceases; it does not. The heart action and respiration go on, but usually in a labored and accelerated way. The sufferer tries in every conceivable way to move but can not. I have heard men hollo out in their sleep and have gone to them. Sometimes they would awake or rather come out of the grip of the attack just by speaking to them. At other times it would take a good sound shaking to relieve them. I think, whatever the cause may be, after a person is fully in the grip of the attack there is for a short time complete suspension of the motor nerves. Predisposing causes may be: Lying on the back, an overcrowded stomach, worms, heavily loaded intestines, excitement or worry over work, etc. But time and again I have been told by one patient in particular, an old gentleman of seventy years, whose habits are almost perfect and one who has plenty of money and all the care and comforts that money can bring, that none of the commonly supposed predisposing causes seem to have any tendency to bring on an attack with him; and I think his attacks are more frequent and more severe than any I have ever seen. I have had these attacks myself and I know that it is a terrible feeling. One feels just as if he were going to die, and I believe if it lasted very long he would die, but fortunately, while it seems like a long time to the sufferer, the attacks only last a very short time, and the person usually awakes himself even if no one comes to help him. But the attacks are so dreadful and the suffering so intense that no time should be lost

in going to the relief of one with an attack of the nightmare. And then do not trust to just speaking to the person, but give him a good shaking. As I said before, the great majority of the cases will come out of the attack without help, but I believe that sometimes they do not, and if the truth were known, some of the deaths found where the person went to bed in perfect health, were due to these attacks of nerve suspension. As to treatment of this condition I have absolutely found nothing, but I am inclined to think that the position in which the person lies when asleep has much to do with the bringing on of an attack. People who are troubled with this condition ought to try to keep from sleeping on their backs. I think the blood gravitating to the most dependent part of the lungs (the back), and forming a temporary stasis, may have something to do with it. They should try to accustom themselves to sleep on their right sides. I don't believe the stomach has much to do with this condition, but it might be well to make the evening meal light, and eat it early.

On the theory of cerebral irritability, a dose of bromide of potassium might be taken at bedtime.

I think this subject is of importance enough to be opened for discussion, especially as there is so little known about it. I would be glad to hear this subject discussed through this journal.

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#### ANGINA PECTORIS.

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For convenience sake we divide angina pectoris in angina pectoris vera and angina pectoris vasomotoria. The term pseudo-angina is incorrect, inasmuch as angina is a term used to designate a symptom, and a very characteristic one at that, and to speak of pseudo-symptom is, if not more or less a contradiction, at least an incorrect use of terms.

Angina vera is generally caused first by coronary sclerosis or sclerosis of the aorta, which narrows the mouths of the coronary vessels, they themselves being normal. Secondly, aortic insufficiency and less frequently other valve lesions. An aneurysm of any part of the ascending aorta, but especially frequent with involvement of the sinuses of valsalva.

In acute dilatation of the heart there is occasionally severe pain, which at times takes on the character of a typical angina. In these cases the coronary vessels are generally normal, and the pain is probably due more to the dilatation than to a coronary spasm. These cases occupy middle ground between the cases of angina pectoris vera and the cases of angina pectoris vasomotoria.

The vasomotor anginas are associated with the following conditions: Nicotinism, or tobacco angina. This usually occurs from acute overindulgence of semi-occasional smokers. Some cases of angina pectoris are due to the abuse of coffee and tea, but these cases are much rarer than those due to tobacco. Closely associated with these are the cases occasionally seen in Basedow's disease. The so-called gastrointestinal cases are, in most instances, merely cases in which both gastrointestinal and cardiac symptoms occur in a highly neurotic subject.

Treatment—Some writers advise a subcutaneous injection of not more than one-sixth of a grain of morphia, to alleviate the most intense pain, while others consider it dangerous and warn against its use. Personally, I have had always good results from it. Of course, the classical remedy for the relief of the attack is amyl nitrite, introduced by Lauder Brunton. And yet the experiences of many clinicians vary so widely that the discrepancies can hardly be explained. Mackenzie, for instance, considers it the best of all remedies, but says that the drug is not successful in all cases, but in many its action is so rapid that the relief is generally complete. Romberg, however, considers it practically useless, and says that in only one



case has he seen any material improvement from its use. Hirsch says that he has never been able to convince himself of any favorable action.

This would lead one to think that many of the supposedly favorable results depend more upon the spontaneous cessation of the pain than on the therapeutic effects of the drug. To me it seems that the good effects of the drug are always seen in cases due to incipient coronary sclerosis, while cases due to other causes are apt to yield more readily to other treatment. One thing, however, is to be remembered, and that is that the lowering of the blood pressure by the action of the amyl nitrite is so short that it had better be supplemented by the use of the slower-acting nitrites, nitroglycerin, for instance. And that reminds me that a small tablet of nitroglycerin absorbed from the tongue acts almost instantaneously.

It must not be forgotten that considerable can be done in the way of treatment in the interim, that is between attacks. When a case of angina vera is associated with coronary sclerosis, or sclerosis of the aorta, or with aneurism, the general treatment of arteriosclerosis must be carried out. While it is advisable to inform the patient of his true condition, yet the outlook should be pictured as favorable as possible to avoid the production of neurasthenic symptoms. The most valuable drug for continuous administration is potassium iodide or one of its substitutes in moderate doses, say five grains t. i. d.

The best results are obtained by the continuous administration of small doses of digitalis, since the condition of the heart is frequently one of slight insufficiency. This is specially valuable with mild but oft-repeated attacks. The question of diet is all important. It should be reduced to the smallest amount which will maintain the patient's weight in equilibrium. The proteid content should be low, well below a hundred grams per day, and the main bulk of the diet should be made up of milk, cereals, vege-

tables and fruit. Especial attention must be paid to the avoidance of flatulence, since it seems quite certain that overdistention of the stomach is very likely to precipitate an attack. It is advisable to inquire into any idiosyncrasy of the patient in regard to flatulence being produced by certain articles of diet, and such articles of diet must be avoided. The amount of salt had better be kept low, but it is probably not wise to eliminate it entirely. Smoking should be absolutely forbidden, and alcohol if not entirely prohibited at least be reduced to a small glass of light wine with the meals. Constipation must be positively avoided, partly on account of the clogging of the excretory vessels and partly because straining at stool may prove disastrous on account of the considerable rise of blood pressure. The same is true of the sexual act.

Patients with angina pectoris should diminish their physical work, and avoid as far as possible all mental worry.

#### PROPAGANDA FOR REFORM.

BARBITAL (VERONAL) CLASSED AS A POISON BY ENGLAND.—Because of frequent reports of accidents and habit formation, the Privy Council of Great Britain has classified as poisons "diethylbarbituric acid, and other alkyl, aryl, or metallic derivatives of barbituric acid, whether described as veronal, proponal, medinal, or by any other trade name, mark or designation; and all poisonous urethanes and ureides." As a result veronal will seldom be dispensed except on a physician's order, and that a record of such sales will be kept in the pharmacist's poison book. (The official name for diethylbarbituric acid of the British Pharmacopoeia is barbitone; in the United States the official designation for this product is barbital.) (*Jour. A. M. A.*, March 30, 1918, p. 953.)

COMPATIBILITY OF PHENOLPHTHALEIN.—It is better not to combine several laxatives, but those who believe in doing this may combine phenolphthalein with drugs that can properly be prescribed in powders or pills as,

for instance, calomel. Since phenolphthalein and calomel are both tasteless, they may be prescribed in powders or enclosed dry in capsule, cachet or wafer, the amount of each ingredient being estimated according to the susceptibility of each patient. (*Jour. A. M. A.*, March 30, 1918, p. 950.)

**HYPOPHOSPHITES FOR THE ARMY.**—The purchasing department of the medical department of the U. S. Army asks for bids on three tons, on one-pound bottles, of the "Compound Syrup of Hypophosphites." These six thousand bottles of a relic of past generations must be paid for and are to occupy valuable freight space in shipping to various Army posts. (*Jour. A. M. A.*, March 16, 1918, p. 783.)

**MEDEOL SUPPOSITORIES.**—The Council on Pharmacy and Chemistry reports that Medeol Suppositories appear to be an imitation of Anusol Suppositories, which in 1907 were found inadmissible to New and Non-official Remedies. "Anusol" was formerly said to be bismuth iodoresorcinsulphonate, but after publication of an analysis in the A. M. A. Chemical Laboratory in 1909, this claim was abandoned and today Anusol Suppositories are said to contain unstated amounts of the indefinite "bismuth oxiodid and resorcinsulphonate." "Medeol" is said to be "resorcinated iodo bismuth," but no information is vouchsafed as to the character or composition of the ingredient. As the composition of the two preparations are similar, so are also the therapeutic claims. The Council declared Medeol Suppositories inadmissible to New and Nonofficial Remedies because their composition is secret, because unwarranted therapeutic claims are made for them, because the name is objectionable, and because the combination is unscientific. (*Jour. A. M. A.*, March 9, 1918, p. 719.)

**MELUBRIN.**—Chemically, melubrin is closely related to antipyrine. It acts as an antipyretic and analgesic and is said to be useful in sciatica, neuralgias and in febrile affections, and as an antipyretic in febrile affections. In Sollmann's Pharmacology, in

a discussion of coal-tar antipyretics, it is stated that practical experience has shown that acetphenetidin, acetanilid and antipyrine are the most useful representatives of the group, and that all the others may well be spared. (*Jour. A. M. A.*, March 23, 1918, p. 874.)

**SHOTGUN NOSTRUMS.**—As the soldier of today uses a rifle instead of a blunderbuss, so the modern physician uses single drugs rather than shotgun mixtures. There are many types of "shotgun" nostrums. Some are dangerous, as in the case of "Bromidia"; some are preposterous therapeutic monstrosities which excite the contempt of educated physicians, as in the case of "Tongaline"; some are merely useless mixtures of well-known drugs sold under grotesquely exaggerated claims, as in the case of "Peacock's Bromides." It is impossible to determine from the published formulas just how much hydrated chloral and potassium bromide Bromidia contains, but it is probable that there are about 15 grains of each of these two drugs to the fluidrachm and variable amounts of Indian cannabis and a small amount of either extract or tincture of hyposcyanus. Bromidia is a distinctly dangerous mixture for indiscriminate use, particularly so if the advertising creates the impression that in it the chloral hydrate has been deprived of its untoward effects. Tongaline is said to consist of tonga, cinicifuga racemosa, sodium salicylate, colchicum and pilocarpin. This jumble of drugs would be merely ludicrous, if anything that degrades therapeutics could be considered so lightly. Peacock's Bromides is said to consist of the bromides of sodium, potassium, ammonium, calcium and lithium. The exploiters claim superiority over extemporaneously prepared mixtures because of the absence of contaminating chlorids said to be present in commercial bromids. The truth is that the chlorids are used as antidotes in bromid poisoning. Bromidia, Tongaline and Peacock's Bromides have been the subject of reports of the Council on Pharmacy and

Chemistry. (*Jour. A. M. A.*, March 2, 1918, p. 642.)

**SODIUM CYANID.** — Loevenhart, Lorenz, Martin and Malone report experiments looking toward the use of sodium cyanid, administered intravenously, as a means of stimulating respiration in threatened collapse from drowning, etc. (*Jour. A. M. A.*, March 9, 1918, p. 692.)

**SOME MISBRANDED NOSTRUMS.**—"Notices of Judgment," reporting prosecutions for misbranding under the Federal Food and Drugs Act, have been issued for the following: Hayseen's Sure Goitre Cure Balsam, a solution of potassium iodid in water, sugar and alcohol. Hayseen's Sure Goitre Ointment, containing petrolatum and potassium iodid. MacDonald's Atlas Compound Famous Specific No. 18, consisting essentially of sodium sulphate, sodium bicarbonate, a laxative plant drug (apparently aloes), ginger, a small amount of phosphate, a trace of alkaloid and talc. Faucine, said to be a "warranted remedy" for piles, diarrhea, dyspepsia, scratches of horses and "good" for female complaints, "hog cholera" and other conditions. Contrell's Magic Troche, containing a little ipecac and claimed to cure catarrh, asthma and diphtheria. Benn Capsules contain strychnin, arsenic, iron and water soluble sulphates, and are sold as a cure for dyspepsia, backache, headache, leucorrhea, falling of the womb, etc. Collins' Voltaic Electric Plasters, claimed to relieve pain and inflammation of the kidneys, of value in fever and ague and "good" for simple bone fracture, and would relieve many cases of bronchitis and asthma, female weakness, etc. Mother Noble's Healing Syrup, containing vegetable cathartic drugs, iron chlorid, Epsom salt and sand. Stuart buchu and Juniper Compound, containing no appreciable amounts of buchu and juniper. (*Jour. A. M. A.*, March 9, 1918, p. 718).

**TYREE'S ANTISEPTIC AND ASEPTINOL.** — Revolutionary changes in the medical sciences have been so numerous and so rapid that the general practitioner has been unable

to keep pace with them. In the resulting confusion the nostrum maker has seen his opportunity for exploiting his useless, unscientific or dangerous preparation. Because of the danger of therapeutic chaos, the American Medical Association established the Council on Pharmacy and Chemistry to place the results of therapeutic progress before the medical profession in an impartial manner. Are you availing yourself of the work of the Council, or are you prescribing proprietaries on the advice of their promoters or are you using drugs of established value? Are you prescribing "Tyree's Antiseptic," so-called, or are you using an antiseptic about which there is no mystery, for which no false claims are made and which is really effective?

Tyree's Antiseptic Powder was claimed to be a combination of "borate of sodium, alumen, carbolic acid, glycerin and the crystallized principles of thyme, eucalyptus, gaultheria and mentha." "Pulv. Aseptinol Comp." is claimed to combine boric acid, the salts of aluminum, crystallized phenol, and the active crystalline principles of thymus, mentha and gaultheria. As a twin may differ from his brother by a wart, so Aseptinol was claimed to contain *hydrastis canadensis* in addition. An analysis of Tyree's Powder showed it to be essentially a mixture of boric acid, zinc sulphate with insignificant amounts of odorous principles. In view of the misrepresentation in one case, it is difficult to understand why it should have been taken for the model of the other. These twin nostrums have been exploited by similar preposterous claims; they are utterly unfit for the treatment of the various conditions for which they are or have been recommended.

More important than the relative merits of nostrums such as these is the question whether the medical profession is going to help to perpetuate the chaotic conditions that the use of such nostrums fosters. (*Jour. A. M. A.*, March 30, 1918, p. 949.)



## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or P. O. Box 136, Jacksonville, Fla., U. S. A.

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**Next Meeting — Tampa — May 15, 1918**

## THE NATION CALLS THE PROFESSION.

The Surgeon General of the Army has issued an appeal for additional medical officers. The time is at hand when the individual counts for naught. We are at war. We have to win the war and we will win the war; the medical profession is going to be a factor.

THE JOURNAL has in previous issues discussed the needs of the Army in so far as relates the demands on the medical profession. The Surgeon General states: "I can not emphasize too strongly the supreme demand for medical officers \* \* \* It is not now a question of a few hundred medical men volunteering for service, but it is a question of the mobilization of the profession that, in the large centres of population and at other convenient points as well as at all Army camps and cantonments, boards of officers have been convened for the purpose of examining candidates for commission in the Medical Reserve Corps of the Army."

It is the opinion of the JOURNAL that the medical profession of the country shared the optimism of the laity and that neither fully realized the sacrifices necessary to win the war. We believe that the country is now awakening and that when a department head states certain materials or man power is necessary in his department, he is going to promptly receive what he asks for. The Surgeon General of the Army estimates that he needs five thousand additional medical officers at once and that at least twenty-five hundred additional officers will be needed every year during the continuation of the war. He will get them—and Florida will do her share.

THE JOURNAL appeals to every member of the Association who feels that he can be spared from the community to at once make application for commission in the Medical Reserve Corps.

We have good reason to be proud of what this state has done during the first year of the war. We have sent 228 of our number into the service, this representing 17.2 per

cent of our medical population which is placed at 1,321. Florida with these figures leads the entire south and ranks eleventh in the whole of the United States. Let us maintain our lead in the south and move up a few pages in our relative rank in the United States.

G. E. H.

### THE MEDICAL PROFESSION IN THE ARMY.

Florida has contributed a goodly number of her medical profession to the big cause. These physicians now in the service are prohibited by regulations to enter into any campaign relative to pending legislation. There are a number of bills now pending in Congress having in view the betterment of the medical officer. The least his confrères in civil life can do to further this legislation is to importune their representatives and senators to support these bills. We publish below editorials that have appeared from time to time in *The Journal of the American Medical Association*:

#### INCREASED RANK AND AUTHORITY FOR MEDICAL OFFICERS.

The time has come to make a final effort to impress on Congress the importance of an early and favorable consideration of the Owen and Dyer bills. It is not necessary to recapitulate the fundamental arguments that call for congressional approval of this legislation. However, we must here emphasize that the success of this measure is desired primarily in the interest of the sanitary and health conditions of the Army.

The sanitary service of troops is not an imposition or a necessary evil, as Colonel Ford<sup>1</sup> has pointed out in the introduction to his work on military hygiene and sanitation, but an effort to assist the commander in preserving the health, and thus the number and morale of his troops. It is an essential and integral part of the military organization. If the sanitary service is to operate to

its full efficiency, its advice must be consulted and its orders must be obeyed. "Discipline is essential for the proper enforcement of orders affecting health," says Colonel Ford. "The sanitary adviser can do nothing if his recommendations are not enforced by the commanding officer. Under similar circumstances the morbidity of those commands whose discipline is lax, is invariably higher than is that of those whose discipline is strict. \* \* \* In the last analysis, however, responsibility for the health of the command rests upon its commanding officer."

Although it is true that the health of the troops under the administration of our Army today is an indication of the judgment and experience of the commanding officer, the fact remains that if epidemics arise, if there occurs an increased morbidity and mortality among the troops, if anything even remotely affecting the good health of the troops receives publicity, the Medical Department is called to account. The public does not criticize the commanding general or the War Department as a whole; it is the Medical Department which receives the blame and which must appear before the bar of public opinion to justify its work and its ability. Every one knows that the primary purpose of the Army is military efficiency, and that important as are hygiene and sanitation, they must sometimes be ignored. As Ford says, "Military exigencies must dominate before an engagement, during it and perhaps after it." But when troops are in camp undergoing training over long periods of time, as are our troops at present, the medical and sanitary officer should not be in the position of a mere adviser of little rank whose recommendations may be considered by a line officer as the latter's judgment or disposition may indicate. The medical officer should be given rank sufficient to command the wholesome respect and consideration of line officers, and with this rank should be authority to enforce an important order without bias against his future Army life.—*Journal A. M. A.*

1. Ford, J. H., Colonel M. C., U. S. Army: *Elements of Field Hygiene and Sanitation*, Philadelphia, P. Blakiston's Son & Co., 1917.

LEGISLATION FOR COMMUTATION OF  
QUARTERS FOR COMMISSIONED  
OFFICERS IN THE FIELD

For some time an effort has been made to obtain for officers on field duty with troops the commutation for quarters, light and heat that is now given to officers stationed where public quarters are not available. A bill has been introduced into the House of Representatives and into the Senate to procure this commutation for officers and dependents while on duty with troops. The bill was referred to the Military Committee and returned to the Senate with a favorable report consisting of an explanation by the Secretary of War of the necessity for immediate action. The bill provides that quarters and commutation thereof to all commissioned officers of the Army on duty in the field, or on actual duty outside the United States, who maintain a residence for wife, child or dependent parent, shall be furnished at the place where the residence is maintained, without regard to personal quarters furnished to the officers elsewhere. The number of rooms prescribed in the act of March 2, 1917, is to govern, and in case quarters are not available, every commissioned officer is to be paid commutation thereof at the rate authorized by law in cases

in which public quarters are not available. The Secretary of War calls attention to the fact that officers serving with troops are actually undergoing privation incident to personal service, particularly abroad. The matter has been considered especially by the *Defense Bulletin*, published by the Army League of the United States, and by the *Infantry Journal*, which present the foregoing table.

This is a problem which affects every medical officer, and certainly justice demands that the bill receive favorable consideration. —*Journal A. M. A.*

PETITION CONGRESS.

No arguments should be necessary to convince civilian physicians of the necessity for the success of some such legislation as that provided by the Owen and Dyer bills for increased rank and authority of medical officers. It should be remembered, however, that Congress, which usually is busy in time of peace, is even more pressed with work in time of war, and however anxious the individual congressman and senator may be to inform himself completely on each measure before casting a vote, the demands on his time are such that frequently this is impossible. There has arisen, therefore, the method of influencing Congress by a direct appeal from the citizens of the country to their representatives. In view of this fact, the American Medical Association last week sent to every county society in the country an appeal to take up this matter individually and collectively, and to petition the senators representing their state and the congressman representing their county to support this measure. An organized appeal of this character, backed by the request of the physicians of the country and supported in turn by the citizens with whom physicians may have influence, will cause Congress to give these appeals the special consideration which they merit.—*Journal A. M. A.*

Table showing the difference in average monthly pay (including commutation of quarters, heat, and light) of officers on duty at Washington and others of like grade on duty with troops at Camp Meade, a few miles distant.

Grade	Monthly Pay at Washington.	Monthly Pay at Camp Meade.	Monthly Premium for Privilege of Serving with Troops.	Percentage of Reduc- tion in Pay for Service with Troops.
Second Lieut.	\$173.66	\$141.67	\$ 31.99	18
First Lieut. . .	212.79	166.67	46.12	22
Captain . . . . .	259.74	200.00	59.74	23
Major . . . . .	323.27	250.00	73.27	23
Lieut.-Colonel	378.83	291.67	87.16	24
Colonel . . . . .	444.14	333.33	110.81	25



APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.

Sir:

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....
4. When and where were you naturalized? (For applicants of alien birth only.).....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....
10. If either parent or brother or sister has died, state cause and age in each case:.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc.:.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates: .....
16. With what ancient or modern languages or branches of science are you acquainted?.....

\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.

17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result : \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and **sworn** to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.

## THE VOLUNTEER MEDICAL SERVICE CORPS.

The Council of National Defense today authorized the following statement:

For the purpose of completing the mobilization of the entire medical and surgical resources of the country, the Council of National Defense has authorized and directed the organization of a "Volunteer Medical Service Corps," which is aimed to enlist in the general war-winning program all reputable physicians and surgeons who are not eligible to membership in the Medical Officers' Reserve Corps.

It has been recognized always that the medical profession is made up of men whose patriotism is unquestioned and who are eager to serve their country in every way. Slight physical infirmities or the fact that one is beyond the age limit, fifty-five years, or the fact that one is needed for essential public or institutional service, while precluding active work in camp or field or hospital in the war zone, should not prevent these patriotic physicians from close relation with governmental needs at this time.

It was in Philadelphia that the idea of such an organization was first put forward, Dr. William Duffield Robinson having initiated the movement resulting in the formation last summer of the Senior Military Medical Association with Dr. W. W. Keen as president—a society which now has 271 members.

Through the Committee on States Activities of the General Medical Board the matter of forming such a nation-wide organization was taken up last October in Chicago at a meeting attended by delegates from forty-six states and the District of Columbia. This committee, of which Dr. Edward Martin and Dr. John D. McLean—both Philadelphians—are respectively chairman and secretary, unanimously endorsed the project. A smaller committee, with Dr. Edward P. Davis, of Philadelphia, as chairman, was appointed to draft conditions of membership, the General Medical Board unanimously endorsed the committee's report, the Execu-

tive Committee—including Surgeons General Gorgas of the Army, Braisted of the Navy, and Blue of the Public Health Service—heartily approved and passed it to the Council of National Defense for final action, and the machinery of the new body has been started by the sending of a letter to the State and County Committees urging interest and the enrollment of eligible physicians.

It is intended that this new corps shall be an instrument able directly to meet such civil and military needs as are not already provided for. The General Medical Board holds it as axiomatic that the health of the people at home must be maintained as efficiently as in times of peace. The medical service in hospitals, medical colleges and laboratories must be up to standard; the demands incident to examination of drafted soldiers, including the reclamation of men rejected because of comparatively slight physical defects; the need of conserving the health of the families and dependents of enlisted men and the preservation of sanitary conditions—all these needs must be fully met in time of war as in time of peace. They must be met in spite of the great and unusual depletion of medical talent due to the demands of field and hospital service.

In fact, and in view of the prospective losses in men with which every community is confronted, the General Medical Board believes that the needs at home should be even better met now than ever. The carrying of this double burden will fall heavily upon the physicians, but the medical fraternity is confident that it will acquit itself fully in this regard, its members accepting the tremendous responsibility in the highest spirit of patriotism. It will mean, doubtless, that much service must be gratuitous, but the medical men can be relied upon to do their share of giving freely, and it is certain that inability to pay a fee will never deny needy persons the attention required.

It is proposed that the services rendered by the Volunteer Medical Service Corps shall be in response to a request from the



Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the Public Health Service, or other duly authorized departments or associations, the general administration of the corps to be vested in a Central Governing Board, which is to be a committee of the General Medical Board of the Council of National Defense. The State Committee of the Medical Section of the Council of National Defense constitutes the Governing Board in each state.

Conditions of membership are not onerous and are such as any qualified practitioner can readily meet. It is proposed that physicians intending to join shall apply by letter to the Secretary of the Central Governing Board, who will send the applicant a printed form, the filling out of which will permit ready classification according to training and experience. The name and data of applicants will be submitted to an Executive Committee of the State Governing Board, and the final acceptance to membership will be by the national governing body. An appropriate button or badge is to be adopted as official insignia.

The General Medical Board of the Council of National Defense is confident that there will be ready response from the physicians of the country. The Executive Committee of the General Medical Board comprises: Dr. Franklin Martin, Chairman; Dr. F. F. Simpson, Vice-Chairman; Dr. William F. Snow, Secretary; Surgeon General Gorgas, U. S. A.; Surgeon General Braisted, U. S. Navy; Surgeon General Rupert Blue, Public Health Service; Dr. Cary T. Grayson, Dr. Charles H. Mayo, Dr. Victor C. Vaughan, Dr. William H. Welch.

#### OUR HONOR ROLL.

Our Honor Roll as published below now constitutes a grand total of one hundred and forty-four physicians. They are divided in the services as follows: Medical Corps—Lieutenant Colonel, 1; Medical Reserve Corps—Majors, 13; Captains, 28; 1st Lieutenants, 89; total, 131. United States Navy

—Passed Assistant Surgeons, 2; Assistant Surgeons, 3; total, 5. National Guard United States (Fla.)—Majors, 3; Captain, 1; 1st Lieutenants, 4; total, 8. The list is gradually becoming complete; we urge all to help us maintain it in a thorough manner.

#### MEDICAL CORPS, U. S. ARMY.

*Home Address.*

Lieut.-Colonel Joseph Y. Porter.....Key West

#### MEDICAL OFFICERS' RESERVE CORPS.

Major Frank E. Artaud.....Key West  
Major M. H. Axline.....St. Petersburg  
Major John E. Boyd.....Jacksonville  
Major Frederick G. Barfield.....Jacksonville  
Major Chauncey L. Chase.....Fort Dade  
Major James B. Griffin.....St. Augustine  
Major H. H. Harris.....Jacksonville  
Major Graham E. Henson.....Jacksonville  
Major Frederick E. Jenkins.....Palatka  
Major Frank R. Maura.....Ojus  
Major Lucien B. Mitchell.....Tampa  
Major Harry Peyton.....Jacksonville  
Major Raymond C. Turck.....Jacksonville  
Captain A. E. Acker.....Jacksonville  
Captain E. G. Birge.....Jacksonville  
Captain H. O. Black.....Jacksonville  
Captain Andrew R. Bond.....Tampa  
Captain T. Z. Cason.....Jacksonville  
Captain Lester J. Efrid.....Tampa  
Captain Stanley Erwin.....Jacksonville  
Captain Albert H. Freeman.....Starke  
Captain Julian Gammon.....Jacksonville  
Captain J. Halton.....Sarasota  
Captain Henry Hanson.....Jacksonville  
Captain Maurice E. Heck.....St. Augustine  
Captain Samuel G. Hollingsworth.....Bradentown  
Captain Owen H. Kenan.....Palm Beach  
Captain S. M. R. Kennedy.....Pensacola  
Captain William W. Mills.....Miami  
Captain William B. Moon.....Lakeland  
Captain Frederick C. Moor.....Tallahassee  
Captain John MacDiarmid.....DeLand  
Captain R. B. McLaws.....Tampa  
Captain D. W. McMillan.....Pensacola  
Captain John D. McRae.....Tampa  
Captain Thomas A. Neal.....Sanford  
Captain James B. Parramore.....Jacksonville  
Captain James D. Pasco.....Jacksonville  
Captain J. Y. Porter, Jr.....Key West  
Captain M. B. Swift.....Orlando  
Captain Harry F. Watt.....Ocala  
1st Lieut. Daniel M. Adams.....Panama City  
1st Lieut. Allen M. Ames.....Pensacola  
1st Lieut. C. A. Andrews.....Tampa  
1st Lieut. Harold M. Beardall.....Orlando  
1st Lieut. Henry P. Bevis.....Arcadia  
1st Lieut. James H. Bickerstaff.....Pensacola  
1st Lieut. Everard Blackshear.....Citra  
1st Lieut. Louis B. Bouchelle.....DeLand  
1st Lieut. John T. Bradshaw.....San Antonio  
1st Lieut. Percy H. Brigham.....Branford  
1st Lieut. Herbert L. Bryans.....Pensacola  
1st Lieut. B. A. Burks.....Titusville  
1st Lieut. Fay A. Cameron.....Tampa  
1st Lieut. Chauncey L. Chase.....Fort Dade  
1st Lieut. Joseph H. Chiles.....Cleremont  
1st Lieut. William A. Clark.....Pine Barren  
1st Lieut. J. S. Coker.....Gardner

1st Lieut. Henry B. Cordes ..... Jacksonville  
 1st Lieut. Charles S. Cooper ..... St. Cloud  
 1st Lieut. Wallace P. Crigler ..... Ocala  
 1st Lieut. T. G. Croft ..... Jacksonville  
 1st Lieut. Clinton W. D'Alemberte ..... Pensacola  
 1st Lieut. James S. Davidson ..... Clearwater  
 1st Lieut. Kenneth McC. Davis ..... Westbay  
 1st Lieut. Gaston Day ..... Jacksonville  
 1st Lieut. L. B. Dickerson ..... Clearwater  
 1st Lieut. George W. Dupree ..... Blue Creek  
 1st Lieut. William T. Elmore ..... Gainesville  
 1st Lieut. Orin O. Feaster ..... Mulberry  
 1st Lieut. Nedy L. Gachet ..... Century  
 1st Lieut. Harry C. Gale ..... Key West  
 1st Lieut. Claude V. Gautier ..... Passagrille  
 1st Lieut. Hugh St. C. Geiger ..... Kissimmee  
 1st Lieut. H. M. Ginsberg ..... Pensacola  
 1st Lieut. Paul Goss ..... Mulberry  
 1st Lieut. O. F. Green ..... Mayo  
 1st Lieut. John D. Griffin ..... Lakeland  
 1st Lieut. J. H. Hall ..... Sopchoppy  
 1st Lieut. John Halliday ..... Tampa  
 1st Lieut. Drew R. Handley ..... Jacksonville  
 1st Lieut. MacMiller Harrison ..... Palmetto  
 1st Lieut. John R. Hereford ..... Fort Dade  
 1st Lieut. Frank P. Hixon ..... Pensacola  
 1st Lieut. John C. Holley ..... Pace  
 1st Lieut. H. F. Horne ..... Jacksonville  
 1st Lieut. Roy Howe ..... Daytona  
 1st Lieut. A. L. Izlar ..... Ocala  
 1st Lieut. Edward Jelks ..... Jacksonville  
 1st Lieut. Charles L. Jennings ..... Jacksonville  
 1st Lieut. Charles L. Kennon ..... Jacksonville  
 1st Lieut. Alpheus C. Koon ..... Jacksonville  
 1st Lieut. William J. Lancaster ..... Tampa  
 1st Lieut. Richard Leffers ..... Lakeland  
 1st Lieut. John P. Long ..... Lake City  
 1st Lieut. John W. McClane ..... St. Petersburg  
 1st Lieut. George S. McClellan ..... Wellborn  
 1st Lieut. James R. McEachren ..... Monticello  
 1st Lieut. Harry B. McEuen ..... Quincy  
 1st Lieut. William G. McKay ..... Jacksonville  
 1st Lieut. Earle H. McRae ..... Tampa  
 1st Lieut. H. R. Mills ..... Tampa  
 1st Lieut. George M. Mitchell ..... Jacksonville  
 1st Lieut. Joseph A. Mixon ..... Pensacola  
 1st Lieut. H. P. Newman ..... Bartow  
 1st Lieut. John A. Newnham ..... Cleremont  
 1st Lieut. John K. Norwood ..... Jacksonville  
 1st Lieut. Bascom H. Palmer ..... Tampa  
 1st Lieut. Henry E. Parnell ..... Fort Myers  
 1st Lieut. Archie R. Parrott ..... Jacksonville  
 1st Lieut. James L. Pennington ..... Fountain  
 1st Lieut. J. O. Philips ..... Worthington Springs  
 1st Lieut. William H. Pickett ..... Gainesville  
 1st Lieut. Marion E. Quina ..... Pensacola  
 1st Lieut. Shaler A. Richardson ..... Jacksonville  
 1st Lieut. Dwight M. Rivers ..... Lake City  
 1st Lieut. E. T. Sellers ..... Jacksonville  
 1st Lieut. George W. Sherouse ..... Campville  
 1st Lieut. E. E. Strickland ..... Miccosukie  
 1st Lieut. Baldwin S. Stutts ..... Port St. Joe  
 1st Lieut. G. C. Tillman ..... Gainesville  
 1st Lieut. W. J. Vinson ..... Tarpon Springs  
 1st Lieut. Adam C. Walkup ..... McIntosh  
 1st Lieut. Archie Watson ..... Live Oak  
 1st Lieut. B. L. Whitten ..... Fort Pierce  
 1st Lieut. John M. Whitfield ..... Malone  
 1st Lieut. William E. Whitlock ..... Fort White  
 1st Lieut. Charlton C. Whittle ..... Nocatee  
 1st Lieut. Daniel B. Williams ..... Lake City  
 1st Lieut. Albert H. Willhenson ..... Jacksonville

## THE NAVY.

Passed Assistant Surgeon W. P. Dey ..... Jacksonville  
 Assistant Surgeon Thomas S. Field ..... Jacksonville  
 Assistant Surgeon Boyd Gilbert ..... Pensacola  
 Passed Asst. Surgeon J. Knox Simpson, Jacksonville  
 Assistant Surgeon D. C. Thompson ..... Pensacola

## NATIONAL GUARD UNITED STATES (FLA.).

Major Lorin Green ..... Jacksonville  
 Major Ralph Green ..... Jacksonville  
 Major James H. Livingston ..... Jacksonville  
 Captain W. J. Buck ..... Gainesville  
 1st Lieut. Daniel C. Campbell ..... Marianna  
 1st Lieut. John R. Hawkins ..... Williston  
 1st Lieut. Z. V. Johnson ..... Milton  
 1st Lieut. J. M. Mitchell ..... Millville

# MEETING OF GENERAL MEDICAL BOARD OF COUNCIL OF NATIONAL DEFENSE HELD IN CONNECTION WITH DEDICATION OF WARDEN McLEAN AUDITORIUM AT CAMP GREENLEAF, CHICKAMAUGA PARK, GA.

The dedication of the Warden McLean Auditorium at Camp Greenleaf, the military medical school at Camp Chickamauga, Ga., on March 11th, was made notable not only because of the presence of the Surgeon General of the Army and members of his staff, as well as many distinguished medical men from military and civil life, but also because of the regular meeting there on March 10th of the General Medical Board of the Council of National Defense, usually held in Washington. About 1,000 doctors, who as Medical Reserve Officers are taking the three months' course, accepted the invitation to attend, extended by Dr. Franklin Martin, member of the Advisory Commission of the Council and chairman of the board.

These members of the General Medical Board attended: Dr. Franklin Martin, Chairman; Dr. William F. Snow, Secretary; Surgeon General William C. Gorgas, Dr. Victor C. Vaughan, Dr. William H. Welch, Dr. John Young Brown, Dr. John G. Clark, Dr. Thomas S. Cullen, Dr. Edward P. Davis, Dr. William D. Haggard, Dr. Jabez Jackson, Dr. Edward Martin, Dr. Charles H. Mayo, Dr. Stuart McGuire, Dr. John D. McLean, Dr. Hubert A. Royster.

Introduced by Dr. Martin, Surgeon General Gorgas said he knew of no more important work than the activities being developed at Camp Greenleaf; that the necessity of military medical training is obvious; also that on a visit to England five years ago he learned that the great developments in the English system had been forced by the necessities arising during the Boer War; so, he said, the United States military medical service is being developed by the exigencies now confronting us and would continue after the war. He said he gained from the British service ideas of value for his administration.

Dr. William H. Welch read a statement giving illuminating figures as to the status in the Army and Navy. Men enrolled in the Medical Officers' Reserve Corps, and recommended to the Adjutant-General's office, totaled 21,824, of whom 17,313 have accepted their commissions. Of 5,378 recommended in the Dental Reserve Corps, 5,086 have accepted. Of 1,067 recommended in the Sanitary Corps, 865 have accepted. Of 152 recommended in the Ambulance Service, 138 have accepted. There are 844 officers in the Naval Medical Corps and 103 in the Naval Dental Corps. There are 827 medical and 199 dental officers enrolled in the Naval Reserve Force. There are available in the Naval Medical Reserve Corps, retired officers, acting assistant surgeons and national naval volunteers, naval militia and coast guard, 284 men. Total of officers available for active naval service are 2,257. There are 207 chief pharmacists and pharmacists, 1,000 hospital corpsmen in the regular service and 1,000 in the reserve, making a total available for active service in these branches of 8,207. In February there was an exceedingly satisfactory decline in the admission rates for communicable diseases, as well as for all causes. In the force afloat, the situation as to pneumonia and cerebrospinal fever is very satisfactory. Scarlet fever has been slightly more prevalent than usual, but in no sense epidemic; a very satisfactory decrease in

measles, mumps continues as heretofore. In the fleet there were 1 case of cerebrospinal fever, 20 of German measles, 35 of measles, 167 of mumps, 26 of scarlet fever, 43 of pneumonia, lobar and broncho. Health conditions afloat are highly satisfactory.

Dr. Martin, in expressing the regrets of Surgeon General Braisted, of the Navy, who was unable to be present, said: "I was in Admiral Braisted's office one morning and found him getting reports by telephone from his various naval stations. From 8.30 to 10.30 o'clock every morning he receives these reports, and gives instructions, thus keeping in constant touch."

Before introducing Passed Assistant Surgeon C. P. Knight of the United States Public Health Service, who reported in the absence of Surgeon General Blue, Dr. Martin read the following telegram received from General Blue:

"Washington, D. C., March 9, 1918.

"Dr. Franklin Martin,

"Chattanooga, Tenn. -

"Request that you give publicity to the fact that Public Health Service is greatly in need of the services of competent sanitarians, particularly medical officers, sanitary engineers and scientific assistants. Salaries vary from \$1,800 to \$2,500 per annum. Applicants should address Surgeon General, United States Public Health Service, Washington, D. C., stating in full experience and training which they have had.

"BLUE."

Surgeon Knight's report summarized the good work done under his direction since September, 1917, in the five-mile zone around Chickamauga Park, a zone having 100,000 population, including 60,000 in Chattanooga. Concrete results included: Inspection of 375 restaurants, of which 148 complied with the regulations; 39 barber shops, of which 29 have been furnished cards indicating full compliance; anti-fly campaign; examination of 2,500 employees of restaurants, barber shops and dairies, 3 per cent being dismissed because of having com-



municable disease; complete survey of 3,000 rural homes, accompanied by educational talks resulting in orders for installation of sanitary privies; complete survey of private water supplies; inspection of all industrial plants, with corrections under way; submission of fuller reports by physicians, and all reported cases being tabulated and investigated; inspection of all dairies; pasteurization of about 30 per cent of milk supply; eating establishments compelled to serve pasteurized milk; thorough medical inspection of Chattanooga schools and intensive rural school surveys recommended; providing Chattanooga with full-time physician and 6 Public Health Nurses by the U. S. P. H. S.; establishment of unit for treatment of venereal diseases; conference with Attorney-General of Tennessee which led to Governor Rye's order to Chattanooga Board of Health to proclaim venereal diseases a menace to the civil and military population and directing it to make regulations for control in co-operation with the Provost Marshal, and steps under way to make this a state-wide campaign; and introduction and passage of ordinances in adjacent counties providing sanitary sewage disposal. Lieutenant Commander Knight has been made a deputy health officer by county and city authorities.

Dr. William D. Haggard, of Vanderbilt University, read a statement for the Red Cross which showed that there are 20 base hospitals on active duty abroad and 14 others mobilized of 19 certified as ready for immediate service. Distribution of sweaters to soldiers and sailors and all Red Cross sources totals at least 1,250,000. Authority for Red Cross work within camps has been conferred by an official order signed by the Secretary of War. Contracts for convalescent houses in 4 camps have been let and others will soon be signed. Twenty-seven sanitary units co-operated with federal and state authorities in February in 17 different states. The 4 laboratory cars, "Reed," "Pasteur," "Lister" and "Metchnikoff," have been turned over to

the Army Medical Corps. Venereal clinics are now in operation in 17 camp cities.

Major William F. Snow, reviewing the work of the Committee for Civilian Cooperation in Combating Venereal Diseases, said that military medical advisors have been provided for state Boards of Health, municipal clinics are being placed, and an excellent moving-picture film, "Fit to Fight," has been prepared to be shown at the camps as an educational measure.

Major Edward Martin, reporting for the Committee on States Activities, told of co-operation with the state societies in various ways. Reporting for the Editorial Committee, he mentioned the 6 manuals on medical military practice, all of which have been approved by the Surgeon General's office.

For the Committee on Surgery, Dr. Charles H. Mayo told how data on 21,000 physicians had been gathered and placed on cards convenient for the ready selection of individuals and groups suited for any given task, a duplicate set of which cards has been prepared for the use of the Surgeon General's office in France. Dr. Mayo emphasized the need of reconstructing wounded men, not only for field service, but also for labor after the war, inasmuch as the usual tide of immigration has ceased. Citing the many Government activities in which medicine enters, he said these relations, he believed, could be coordinated in no way except by having a medical man as a Cabinet Officer. He closed with this plea for recognition of medical military men:

"Medical men must have adequate rank. They are entitled to it. For it is not as if they were at work in the military service doing work to which they are new and unaccustomed. They are working in the line to which they have given their lives. They can't do their best unless they have adequate recognition and rank."

In the absence of Miss M. Adelaide Nutting, Chairman, Miss Ella Phillips Crandall, Secretary, reported for the Committee on Nursing. The total nurses enrolled to date

are 18,344, of whom 10,000 have enrolled with the Red Cross since April 6, 1917. The Red Cross had supplied the Army with 6,220 up to March 1, and 1,000 to the Navy and Public Health Service. As insufficiency of nurses in December was due in some camps to lack of housing accommodations, and in others to the fact that a larger quota had not been called for, the committee recommended to the Surgeon Generals of the Army and Navy that suitable accommodations be provided in adjacent towns where necessary; that there be a quota of not less than one nurse to 6 acutely ill men; that a reserve of 25 above the prescribed quota be stationed at each hospital; that Miss Anne W. Goodrich be assigned to inspect military and naval hospitals, and that Superintendents of three-year training schools graduate the 1918 classes early. These recommendations received unanimous endorsement of the Executive Committee of the General Medical Board, the Surgeon Generals and the Secretary of War, since which time all demands for nurses have been met. The committee is continuing its campaign to attract young women into training schools and is cooperating in the courses to be given at Vassar College this summer for young women who shall have registered for entrance to a graduate school of nursing in October, these women then being eligible for graduation in two years instead of three. Appeals to training schools and professional registries, together with the Red Cross campaign for nurse enrollment, will, the committee believes, readily provide the 5,000 additional nurses who, it is expected, will be required by June 1; and that the total of 37,500 graduates will be furnished as needed. The committee is seeking relative rank as recognition for Army and Navy nurses, they having all been provided for in the War Risk Insurance Law through the committee's efforts.

Miss Crandall, also reporting for the Subcommittee on Public Health Nursing of the Committee on Hygiene and Sanitation, told

of an experiment in two states in cooperation with the Food Administration, whereby Public Health Nurses are to have special instruction in food economics.

Dr. Jabez Jackson, of Christian Church Hospital, Kansas City, Mo., spoke of the need of nurses to take the place of experienced nurses who have gone into military service, saying that 12 out of 15 nurses had gone from one hospital in his city. He advocated special attention to nurse apprenticeship in hospitals.

Introduced as President-Elect of the American Medical Association, Dr. Arthur Dean Bevan expressed the confident belief that, whether the war lasts three years or five years and requires 3,000,000 men or 5,000,000 men, the medical profession will continue to stand by "until the job is finished." He said: "It is the one business of the American Medical Association to educate the profession to realize the extent of the work before it. At our great meeting in June I should like to have back with us such men as Osler and Dupage to tell us at first hand something of their work and the need for such work as theirs on the other side."

Major John D. McLean told of the progress of the plans for the Volunteer Medical Service Corps, reading the conditions of membership. This body will be open to reputable physicians ineligible to the Medical Officers' Reserve Corps because they are over the age of 55, on account of physical disability, or because of necessity for home service, or other good reason. "An organization of the doctors at home to do a something when there is a something to do" was the way Dr. McLean summarized the function of this new organization which will act when called upon by the Surgeon Generals of Army, Navy or Public Health Service. He emphasized the fact that this organization "will not protect slackers at home." Dr. McLean exhibited an attractive design proposed for insignia.

Lieutenant Colonel Victor C. Vaughan, reporting for the Committee on Legislation,

told of the request of the Army medical officers for higher rank and greater authority, and of the Owen-Dyer Bill (S. 3748 and H. R. 9563) now pending in Congress. He cited instances which he said indicated need for greater rank, and then read the following letter from President Wilson to Dr. Franklin Martin, endorsing the bill:

"March 5, 1918.

"My dear Dr. Martin:

"I read very carefully your memorandum of February 27th about the rank accorded members of the Medical Corps of the Army and have taken pleasure in writing letters to the chairmen of the Military Committees of the House and Senate, expressing the hope that the bill and resolution may be passed.

"Cordially and sincerely yours,

"WOODROW WILSON."

"Dr. Franklin Martin,

"Advisory Commission,

"Council of National Defense."

The dedication exercises on Monday morning, March 11th, were attended by a throng which filled the auditorium to overflowing. On the stage was a notable group of army medical officers, with a sprinkling of civilian doctors of national and international fame. Lieutenant Colonel Roger Brooke presided. Those on the stage included: Surgeon General William C. Gorgas, Brigadier General J. B. Erwin, in command of Camp Forrest; Colonel Henry Page, Dr. Franklin Martin, Member Advisory Commission, Council of National Defense and Chairman General Medical Board; Colonel E. L. Munson, Lieutenant Colonel V. C. Vaughan, Lieutenant Colonel William H. Welch, John Hopkins University Medical School; Major Charles H. Mayo, President American Medical Association; Dr. Arthur Dean Bevan, President-Elect American Medical Association; Dr. Edward P. Davis, Philadelphia; Major John D. McLean, Major Stuart McGuire, Major George E. de Schweinitz, and many others.

After music by the Camp Greenleaf orchestra and invocation by Bishop Thomas

F. Gailor, Episcopal Bishop of Tennessee. Dr. John G. Clark, of Philadelphia, made the speech of formal presentation of the \$10,000 auditorium on behalf of Mrs. Wm. McLean, whose son, Warden McLean, while in the officers' training camp at Ft. Oglethorpe, was accidentally killed. Coloney Henry Page, who, since his graduation from the University of Pennsylvania School of Medicine in 1894, has been continuously in the regular army and whose efficient, untiring efforts have transformed the site which in 1898 was the dumping ground for the Chickamauga Camp, made the speech of acceptance. He said it is his ambition to have here a great postgraduate training camp, and that he hopes to see the temporary buildings replaced by permanent structures.

He was followed by General Gorgas, who argued convincingly for military training for medical officers. He said that notwithstanding handicaps, the present American Army has established a sanitary world's record, for it has cared for 1,000,000 men and the death rate is 10 men per thousand, whereas Japan during the Russo-Japanese War was deemed to have accomplished marvel when she kept her death rate down to 0 per thousand. "This is but the beginning of Camp Greenleaf," he said. "This probably will be the focus of our medical activities." He said that Camp Greenleaf, located in the geographic center of 450,000 troops in training, seems the logical location for the one great medical training ground, with accommodations there possibly for 40,000 men, trebling its present capacity. He expressed a wish that the Council of National Defense might interest itself in such a project, and he said: "From past experiences I am sure of their interest."

Brigadier General J. B. Erwin, the Commandant at Camp Forrest, adjacent to Chattanooga, in a happy speech indicative of the present cordial cooperation of the line officer with the medical branch of the service, evoked enthusiastic applause when he advocated a detention cantonment for the "laun-



dering" of recruits before they are allowed to mingle with the men in camp—thus decreasing the chances of mumps and measles, diseases which, he said, are certain to break out wherever bodies of men are gathered in camp or barracks.

Lieutenant Colonel Victor V. Vaughan recalled a visit to Berlin in 1901 and a talk with Wassermann, the German medical authority, in which the latter expressed a fear that the 50,000 soldiers quartered in Berlin and the other like units in other cities indicated that "some day" Germany's military leaders would plunge that country in war which might mean the dismemberment of the empire. Dr. Vaughan expressed the hope that some day he might walk through the streets of Berlin and see flying from public buildings the flag, not of France, nor of Britain, nor of the United States, but of the German republic.

Dr. Vaughan, reverting to conditions at Chickamauga as he found them in 1898, when there was not a single microscope nor test tube in the camp, contrasted those conditions with the fact that a medical camp has here been established. He contrasted the attitude of the line officer of those days with the work-together spirit of today.

Dr. Edward P. Davis, of Philadelphia, praised the spirit of the doctors in training, and reminded the audience that physicians really entered the profession of war when they became medical students. "You are soldiers by inheritance and training," he said.

A review in the afternoon of the 12,000 men in the various medical and sanitary units, with a field hospital demonstration, had a dramatic setting. From the knoll overlooking the parade ground from the east several score interned Germans, ranged behind the wire of their stockade, viewed the spectacle, while on the western side of the field was the immense crowd of civilian visitors who came by automobile and trolley. Well in their rear, towering high above, rose historic Lookout Mountain.

The Warden McLean Auditorium build-

ing is situated in the center of Camp Greenleaf. Besides the main assembly hall there are several smaller rooms, including orthopedic museum, library and reference room, lecture rooms, study rooms and office. Since the opening of the camp 4,000 officers and 20,000 enlisted men have been trained and sent to duty abroad or to instruct at other camps.

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### TYPHOID IN AMERICAN CITIES.

In this issue is the sixth annual summary of typhoid death rates in American cities of over 100,000 inhabitants. It need hardly be said that absolute accuracy is not claimed for these figures. Clerical errors are occasionally made in reporting figures to us and exact verification is naturally impossible. It is evident, too, that the usage in reporting typhoid deaths varies somewhat in different communities so that the recorded death rates are in some instances not strictly comparable. One source of error and misapprehension to which reference has been specifically made is the inclusion of deaths of non-residents occurring in city hospitals along with the deaths properly attributed to the city's own population. This procedure naturally tends to exaggerate city typhoid rates generally as compared with the rates in the neighboring suburbs and rural communities. There is, however, no satisfactory means of controlling data of this sort, and it is believed that the practice we have followed in this particular is in general not unfair, especially when the same method is observed consistently through a series of years. It must be remembered also that if non-resident deaths were eliminated from the city figures in each case, it would still not be possible to include the deaths of residents occurring outside the city itself or the deaths due to infection contracted by non-residents within the city limits. In no case can it be maintained that exact accuracy is secured, and the figures that we employ can be regarded as only an approximation.

Making all reservations as to the precision and completeness of the statistical data furnished us, it may be considered that these typhoid summaries have a definite value. It may be true that the relative differences in the typhoid death rates of cities with rates under 5.0 per 100,000 are not specially significant, but there can be little doubt that the difference between those with rates under 5.0 and those with rates over 15.0 is significant and should be taken into account by public health authorities. There is reason to believe, also, that the annual typhoid summaries printed by *The Journal* have had a real influence in stimulating local interest in the typhoid situation, and in a number of instances in causing methods of sanitary reform to be set on foot. *The Journal* has received so many communications to this effect that there is no escape from the conclusion that these annual summaries have been useful to members of the profession and to health officials in many places.

It is of great interest to note the remarkable decline in the total average typhoid rate that has occurred in the large cities of this country since 1910. Whatever be the statistical objections in regard to accepting the figures on their face value, it can hardly be questioned that a very great improvement has taken place in the typhoid situation in this country since the publication of these annual summaries was first begun. The 1917 typhoid death rate in a population of approximately 25,000,000 will bear comparison with the rate in a similar population anywhere in the world. The health officials of American cities deserve great credit for this improvement which has, to a large extent, freed sanitary science in this country from the reproach of excessively high city typhoid. —*Journal A. M. A.*

#### THE GOOD SAMARITAN FUNCTION OF THE MEDICAL CORPS.

Major George de Tarnowsky, M. R. C. (*Review of Surgery and Medicine*, March, 1918, Vol. I, No. 1, prepared in the office of

the Surgeon General) gives one of the best descriptions of the surgery in the zone of advance, from personal observations on the French front. Attention of all medical officers is directed to the following:

"In addition to hot meals which are carried to the soldiers in the trenches, the Medical Corps now sends hot tea, flavored with a small amount of brandy, to the front lines twice daily—a most welcome potion, which the soldiers look forward to with eagerness. The prevailing idea of the French Medical Corps is to make the fighting men feel and know that their comfort is being looked after and that everything is being done to mitigate the hardships under which they live. The French are strong believers in the personal element—the little acts of kindness, even of tenderness towards the individual soldier which have helped to keep up both his fighting spirit and his mental serenity. The 'tisaneries,' as the hot tea stations are called, did not come into existence as the result of army orders; they represent a voluntary contribution to the soldier on the part of the Medical Corps. Begun in a small way, it was soon noticed that, where the 'tisaneries' existed and the regimental kitchens were installed near enough to the trenches so that the food reached the soldier hot, the morale and fighting edge were of the finest."

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#### A NEW REVIEW ON WAR SURGERY.

There has just been prepared in the office of the Surgeon General a new pamphlet, "Review of War Surgery and Medicine" (March, 1918, Vol. I, No. 1). According to the editorial note this review is to appear monthly and to be devoted to abstracts of war medical literature. This little pamphlet will furnish the medical personnel of the Army abstracts of original papers of importance, necessary information in a short compass, and prompt publication of reports which otherwise might not gain circulation.

In this first volume there is a splendid review of Surgery in the Zone of Advance

prepared from data written by Major George de Tarnowsky, based upon his personal observations in the French army front. It is the best description that has yet appeared in American literature of the war.

This is followed by a most readable and instructive review of the most recent data on gas gangrene, trench foot and the general principles guiding the treatment of wounds of war.

Copies of this review may be obtained by addressing the Superintendent of Documents, Government Printing Office, Washington, D. C., enclosing ten cents in stamps.

This review should be in the hands of every officer of the Medical Corps and should be of interest to the entire medical profession not in the service. The reviews are very well written and make most interesting and profitable reading.

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#### SAVE THE CHILD.

The lives of one hundred thousand of the Nation's children are to be saved in a child welfare drive which the Federal Children's Bureau has announced today. The drive will begin on April 6th, one year from the day the United States declared war, and the first day of the Children's Year.

Public health authorities agree that half the deaths of young children are easily preventable. Each State will be assigned a definite quota of the hundred thousand lives to save. State councils of defense and the State women's committees are being called upon to be responsible for the State quotas.

Methods of work will be those which have already proved efficient in saving children's lives in the United States and other warring countries.

To inaugurate the Children's Year a nation-wide weighing and measuring of babies and children of preschool age will be made. No such general test of the well-being of children has ever been attempted. It will show each community what its children need if the men of the rising generation are to be

free from the physical defects which the draft has revealed.

The plans contemplate economy for every purpose except for the essential means of protecting child-life.

In cooperation with the Woman's Committee of the Council of National Defense, and therefore with the principal woman's organizations of the country, the Children's Bureau is preparing plans for a child-welfare campaign for the second year of the war. The first aim of the campaign will be to secure the Public Protection of Maternity and Infancy.

Public health authorities agree that one-half the deaths of infants are easily preventable, and that if children were well born and well cared for there would be practically no deaths of babies. Three hundred thousand American children under five die each year. Authorities also tell us that most of the fifteen thousand mothers who died last year died needlessly.

It is the plan of the Children's Bureau to save a certain definite proportion of these lives. It is believed that one hundred thousand lives can be saved this year notwithstanding the withdrawal of a large proportion of doctors and nurses for war service.

The State councils of defense and the State women's committees are called upon to be responsible for the State quotas. The actual methods by which those lives are to be saved are those whose effectiveness in saving children's lives is already demonstrated. They are described at length in various pamphlets which have been prepared by the Children's Bureau.

Briefly the methods are as follows:

First: The registration of births so that there may be an immediate record of every child born; and nursing and medical skill may be provided wherever family income does not permit its being secured independently.

Second: For every mother prenatal care, necessary care, of doctor and public nurse at confinement, and after care.



Third: Children's conferences where well babies can be taken periodically to be weighed and examined, and clinics where sick children may be given medical advice.

Fourth: The organization of State and city divisions or bureaus of child hygiene.

Fifth: The guarding of the milk supply, that every child may have his quota of clean, pure milk.

Sixth: An income making possible decent living standards.

In 1916 and in 1917 a nation-wide baby week was held under the auspices of the General Federation of Women's Clubs and the Children's Bureau which has resulted in awakening a new sense of civic responsibility for infant-life in thousands of localities, and has secured many new activities such as nursing services, clinics, children's conferences, better milk and food supplies, better enforcement of birth-registration laws.

In many communities the Baby Week celebrations have cost large sums, in others the Baby Week has proved an exceedingly effective means of awakening permanent interest at little or no expense.

Valuable as Baby Week is, however, the present emergency demands a longer and more comprehensive program. After the Nation's soldiers are provided for, the second year of the war should be dedicated by the civilian population to preserving the lives of the Nation's children. Is there any greater patriotic duty for the civilian population than to safeguard the welfare of the Nation's children?

Hence this year the plan is simpler and yet more far-reaching than ever before. It should be far more effective because through the women's committees not only the General Federation of Clubs but all the great women's organizations of the country will lend their cooperation.

Economy in unnecessary expenditures so as to save for essentials should characterize all work this year.

It is known that the examinations of the draft have resulted in a considerable number

of rejections for physical defects which might have been remedied in infancy or early childhood if then recognized. Weight and height constitute on the whole a fair standard of development; how do the young children of the United States measure up to such a standard?

As a test of child-welfare, to inaugurate the Children's Year which begins on April 6th, the anniversary of the declaration of war by the United States, a nation-wide weighing and measuring of babies and children of preschool age is proposed. No general test of children of preschool age has ever been made, and an examination of such children with special reference to weight and height is now proposed as the primary feature of the war time Children's Year.

The Children's Bureau will provide a record card which will be arranged in duplicate so that one-half can be sent in to the Children's Bureau and one-half kept by the parents. The record will be filled out by trained physicians and nurses in many places, but if parents can not take their children to an examining station they can secure cards and make the record themselves. The record card will show the fair standard for children of a given age and parents can judge for themselves where their children stand. Should there be any great divergence from this standard it is a warning that the children's health should be given medical consideration or should be carefully looked after. The records will all be gathered and tabulated by the Bureau. The weighing and measuring experiment can be conducted with little or no expense.

Weighing and measuring should begin as soon as possible after the sixth day of April, and should be concluded within sixty days. It has been suggested that where Baby Week celebrations of any sort are to be held the last six days of this period, being the first six days of June, should be taken for Baby Week. Such celebrations as are held, will, it is hoped, especially emphasize the need of public health nurses and of special protec-

tion for young infants against the various dangers of summer heat.

One of the most remarkable developments of the war, a victory not heralded on front pages, yet which in time to come will be noted by all students of human-welfare is the saving of infant-life in England during the second year of the war. The report of the Chief Medical Officer of the Local Government Board, Sir Arthur Newsholme, published in 1917, shows for one sanitary district after another throughout England and Wales the number of babies who died before the war, those who died the first year of the war and the deaths for the second year of the war, 1916.

It is startling to turn over the pages of this report and to see that the general social confusion of the first year of the war resulted in a large increase in the number of babies who died. But in the second year of the war, when the local government board was enabled to grant financial aid to the various sanitary districts and to secure co-operation in its policy of health visitors for every mother and baby, of health centers for consultation, of hospital care for sick mothers and babies, the rate went down not only far below the rate for the year before, but far below the rate previous to the war.

This record of life-saving in the midst of the strain of war by means so simple and so at command is, we believe, entirely without parallel.

Although the United States now lacks the machinery for such Federal Aid as England was enabled to grant to local work it has power enough locally to make a very creditable showing, and, it may be hoped, to pave the way for such governmental provision as will enable the United States to show the even greater salvage which its unexhausted condition makes possible.

Again, why should the United States, especially the newer rural States, be satisfied with a less favorable infant mortality rate than that which New Zealand can show? The New Zealand rate has steadily gone down,

notwithstanding the war, and is now almost precisely half the rate for the registration area of the United States; that is, in New Zealand one baby in twenty dies, while in the United States one baby in ten dies. The most favorable State rate in the registration area is 70, that of Minnesota. Why should Minnesota not enter the race with New Zealand?

Information has just been received in this country that Dr. F. Truby King, of New Zealand, has sailed for Vancouver on his way to England. Dr. King is known as the active head of the New Zealand Society for the Health of Women and Children, an organization which, in cooperation with the Government, is credited with a large share of responsibility for the lowering of the New England infant mortality rate in recent years. This society was organized when Lord Plunket was Governor of New Zealand, and its nurses are known as Plunket nurses in honor of Lady Plunket, who gave much aid to the society.

It is significant that Dr. King is now going to England to undertake similar work there at the request of a society in which Lord and Lady Plunket are moving spirits.

Dr. Truby King expects to be in the United States about three weeks. He writes that he wishes to be informed as to the latest developments in child-welfare work in the United States, and his plan is to visit various cities where notable work is now under way. The visit of Dr. King just now gives added emphasis to the importance of the nationwide campaign for infant-welfare which the State and National Committees of Defense and the Children's Bureau are undertaking.

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#### NEW AND NONOFFICIAL REMEDIES.

ARSENOBENZOL (DERMATOLOGIC RESEARCH LABORATORIES) 1 CM. AMPULES. — Each ampule contains 1 gm. arsenobenzol (Dermatologic Research Laboratories), a brand of arsphenamine complying with the New and Nonofficial Remedies standards. These ampules are prepared for use in hospitals in

divided doses. Dermatological Research Laboratories, Philadelphia Polyclinic, Philadelphia.

**BULGARIAN BACILLUS TABLETS — MULFORD.**—Tablets containing a practically pure culture of *Bacillus bulgaricus*. Used in the prevention and treatment of conditions due to intestinal putrefaction. Marketed in vials containing fifty tablets. An expiration date is stamped on the label. H. K. Mulford Company, Philadelphia. (*Jour. A. M. A.*, March 2, 1918, p. 623.)

**HALAZONE — MONSANTO.** — A brand of halazone complying with the New and Non-official Remedies standards. Halazone is parasulphonedichloramidobenzoic acid. The Monsanto Chemical Company, St. Louis, Mo.

**PROCAINE — ABBOTT.**—A brand of procaine complying with the New and Non-official Remedies standards. Procaine was first introduced as "novocaine." Chemically it is the monohydrochlorid of para-amino-benzoyldiethyl-amino-ethanol. It is used as a local anesthetic as a substitute for cocaine. The Abbott Laboratories. (*Jour. A. M. A.*, March 16, 1918, p. 119.)

**TYPHOID VACCINE, PROPHYLACTIC.** — A vaccine made from killed *Bacillus typhosus*. The vaccine is used for the prevention of

typhoid fever, for which purpose typhoid vaccines are of recognized utility. Marketed in different sized containers, containing 500 million and 1,000 million killed *Bacillus typhosus* in 1 c.c. Eli Lilly and Company, Indianapolis.

**TYPHOID VACCINE, THERAPEUTIC.** — A vaccine made from killed *Bacillus typhosus*. The vaccine is proposed for the treatment of typhoid carriers and as a concomitant measure to the usual routine of typhoid therapy. Marketed in different sized containers, containing 100, 250, 500 and 1,000 million killed *Bacillus typhosus* in 1 c.c. Eli Lilly and Company, Indianapolis.

**TYPHOID MIXED VACCINE (TYPHO-BACTERIN MIXED).**—A vaccine made from killed alpha and beta *Bacillus paratyphosus* and *Bacillus typhosus*. The vaccine is used for the immunization against typhoid and paratyphoid fevers and in the treatment of mixed infections of the typhoid bacillus and the paratyphoid bacilli. Marketed in different sized containers, containing 250 million alpha and beta *Bacillus paratyphosus* and 1,000 million *Bacillus typhosus* in 1 c.c., and 500 million alpha and beta *Bacillus paratyphosus* and 1,000 million *Bacillus typhosus* in 1 c.c. Eli Lilly and Company, Indianapolis.

## THE FLORIDA MEDICAL ASSOCIATION

WILL MEET IN ANNUAL SESSION

AT

TAMPA

MAY 15th and 16th, 1918

*Organized medicine never had such important functions to perform as at the present time. The profession has to be mobilized to help win the war*

*ATTEND THIS MEETING and shoulder your share of the burden.*



## Publisher's Notes

### ASCENDENCY OF THE AMPOULE.

As evidence of the favor with which the medical profession has come to regard the glaseptic ampoule, it is worthy of note that Parke, Davis & Co. now supply in this form more than eighty sterilized solutions for hypodermic use. The fact is significant when it is remembered that the "ready-to-use" solution is distinctly a modern institution, having its introduction in this country less than ten years ago.

Solutions in ampoules, it is obvious, have several advantages over those prepared in the ordinary way. They are ready for immediate use, any time, anywhere, there being no necessity to wait until water can be sterilized and cooled. Accuracy of dose is insured, each ampoule containing a definite quantity of medicament. The solutions are aseptic; they are permanent.

Parke, Davis & Co. publish an "Ampoules" brochure, a valuable little book of seventy pages, giving a list of their sterilized solutions, with therapeutic suggestions, dosage, descriptions of packages, prices, etc. The work contains a useful therapeutic index and an informing chapter on hypodermic medication in general. Physicians and surgeons are advised to send to the Detroit laboratories of Parke, Davis & Co. for a copy of the book, requests for which are invited.

### THE BULGARIAN BACILLUS AS A REMEDIAL AGENT.

A simple and effective remedy for the summer diarrheas and other common ailments of the intestinal canal is the Bulgarian bacillus. This was popularized a few years ago by the late Professor Metchnikoff, who pointed out that this organism, in the form of buttermilk, is extensively used by the Bulgarians, who have the reputation of being the longest-lived people in Europe. While this lactic acid organism is not, of course, a panacea for senility, it is a remedy of very great value for many intestinal affections. Clock and others have shown that by its use summer diarrheas of children can be controlled more quickly, and with less disturbance of the child's regular food than with any other remedy. It has also been recommended for intestinal indigestion, auto-toxemia of intestinal origin, and even for such serious diseases as diabetes.

It is important to use a culture of the Bulgarian bacillus which you can depend upon. Galactenzyme (Abbott) is such a culture. This product is made from the type A organisms, of established virility, under the most careful, aseptic precautions. It is available both in tablet form and in bouillon. For ordinary use the tablets are generally preferred. We recommend a careful trial of Galactenzyme in cases of summer diarrhea. Now is the time to procure a supply.

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To Regulate The Bowels—For All Ages—At All Times

**Liquid Petrolatum, Squibb**

**Heavy (Californian)**

THE QUALITY MINERAL OIL

**E·R·SQUIBB & SONS**

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

# HEBE



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## The New Food Product

**H**EBE is a compound of evaporated skimmed milk and vegetable fat, a pure, wholesome food. We take fresh, sweet, pure whole milk and extract the butter (or animal) fat, replacing it with vegetable fat—highly refined cocoanut fat. Hebe contains a minimum of 7.8% fat, and 25.5% total solids.

Hebe has been tested and recommended as follows:—

### for **Coffee**

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# THE JOURNAL — OF THE — Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV  
No. 10

St. Augustine and Jacksonville, Fla., April, 1918

Yearly Subscription, \$1.50  
Single Copy, 15c.

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, April, 1918

Number 10

## ORIGINAL ARTICLES

### PRACTICAL EUGENICS.\*

JOHN JOSEPH KINDRED, M. D.,

New York City.

Eugenics may be defined as the science of race improvement by the application of the laws of heredity. Medically speaking, it is what might be called a prophylaxis (preventive) against further impairment of the human race. When we consider that of the 2,500,000 children that are born in the United States annually, there are about four per cent of this number, or 100,000, who are so defective, mentally, physically or morally, as to be a burden to themselves and others; and that one-fifth, or 500,000, of the total number are so weak and unfitted for life's battle that they die in infancy or early childhood; and that one-half of the total number born annually die before reaching their twenty-third year, we must see that bad or vicious heredity is the cause of such incalculable economic waste, not to speak of the sadness and race impairment brought about by such an ominous sociological state of things. When we find that there are yearly cared for in the hospitals, asylums and homes in the United States over 300,000 insane and feeble-minded, over 150,000 criminals in and outside of prisons; several hundred thousands in our almshouses and similar charitable institutions, and over 150,000 blind and deaf; besides the thousands of "monkey geniuses" and inspired idiots and fools of all ages, we naturally ask where will these serious conditions, racially and sociologically and economically, finally lead? While bad environment is the cause of some of these conditions, bad heredity is clearly the chief cause. It is well understood from a thorough

study, extending over many years, of thousands of criminals, juvenile delinquents and persons of notoriously bad moral character that considerably over one-half of these troublesome classes possess inherited, inborn defects, which account for their abnormal conduct and condition. Many of them are strikingly abnormal in their physical make-up, having anthropological faces and bodies and other marks of stigmata (signs of degeneration in their faces and bodies) of an inherited type.

It is this cause we, as physicians and humanitarian workers, have studied and which we ask you to consider with a view of so arousing the great public — the average thinking man and woman — that we can put into operation better rules and laws bearing on this subject in order to breed a better race. But before we discuss this phase of the subject, that is the prevention of racial impairment or what physicians term prophylaxis, attention is invited to some of the basic laws governing heredity, or the inheritance by the child of the qualities and traits, mental, moral and physical, of the parents. The question of children inheriting the characteristics of their parents, grandparents and great-grandparents is well settled not only in science but in the popular mind. "Like father, like son," is a very old saying, having its foundation in the simplest laws of heredity. This is so true that it has been said by eugenic scientists that every trait of a child has been inherited — some from its parents; some from its grandparents and some from its great-grandparents; the different traits very much like the arrangement of the different colored tiles which lie side by side in a tiled floor — some traits like some individual tiles black and bad, some white and pure, while others are good, bad and indifferent,

\*Read by invitation before the Volusia County Medical Society, March, 1918.



exactly according to the traits, mental, moral and physical, possessed by the parents, grandparents and great-grandparents and in the proportions stated by Galton's Law of Inheritance, which is that as an average in hundreds of thousands of cases we inherit one-fourth from each parent, one-sixteenth from each grandparent, one-sixty-fourth from each great-grandparent, the remaining eighth being the result of the efforts of ourselves; this latter one-eighth being derived from what has been called our higher heredity of ourselves. Mendel's law is also frequently quoted in these studies. According to Mendel all our characteristics are inherited, as so-called unit characters from each parent, and these are stated by Davenport as being inherited as single, simplex or as multiplex characters, or if certain characters do not exist at all in either parent, as nulliplex characters. His theory presupposes that these unit characters are transmitted by each parent to the child by a process of amphymixis, which means that in the union of the sex cells of both parents to form the child, character determiners (chromosomes) are developed in the future child in proportion exactly as they may be possessed by each parent, for example:

If one parent has the characteristic simplex and the other duplex, then half the offspring will have it simplex and the other duplex. The inheritance or non-inheritance of some of these traits like hair, the color of the eyes, etc., which so well illustrates the precision of the modern science of heredity, though originally considered to be immaterial to well-being, are important, if the observations of Major C. E. Woodruff, that pigmentation protects individuals from the injurious effects of the tropical sun's rays, etc., can be accepted.

Dr. A. J. Rosanoff, following the Mendelian theory and applying it to the inheritance of insanity and neuropathic states, has formulated the theoretical expectation of different kinds of offspring, as follows:

(1) Both parents being insane, all the children will be insane.

(2) One parent being normal but with an inherited insane taint from his ancestors, and the other parent being frankly insane, half the children will be normal and the other half will be insane; but even the normal children from such a mating will carry the taint of insanity in their germ plasm and will be capable of transmitting it to subsequent generations.

(3) One parent being normal and of pure normal ancestry and the other parent being insane, all the children will be normal but will all carry the insane taint in their germ plasm.

(4) Both parents being normal but each with the insane taint from the ancestors, one-fourth of the children will be normal and not capable of transmitting insanity to their progeny; one-half will be normal but capable of transmitting the insane make-up, and the remaining one-fourth will be insane.

(5) Both parents being normal, one of pure normal stock and the other with the insane taint from his ancestors, all the children will be normal, but half of them will carry the taint of insanity in their germ plasm.

(6) Both parents being normal and of pure normal stock, all the children will be normal and entirely free from the taint of insanity.

Theoretical expectations and actual findings, as related to the Mendelian theory, do not, as is to be expected, always show an exact correspondence but are expression of possible chance. Dr. Rosanoff's tables relating to neuropathic offspring and normal offspring, according to the Mendelian theory, are well worth studying and justify the conclusion, he thinks, that insanity is transmitted from generation to generation according to the Mendelian theory.

These six possible combinations should always be borne in mind in our efforts to solve the marriage and mating problem of not only those suffering with the frank symptoms of inherited insanity but those normals with whose sane and human feelings and instincts are more difficult to deal with in this regard because many of these often

represent the highest and most admirable qualities of heart and mind.

The study of the laws of heredity prove that there is a direct inheritance of (and diathesis to) such mental and neuropathic diseases as the manic-depressive psychosis, dementia præcox, epilepsy, imbecility, idiocy, feeble-mindedness, Huntington's chorea, Friedrich's disease (hereditary ataxia), Thompson's disease, familial tremors, muscular atrophies and dystrophies, multiple sclerosis, cerebral hemorrhage, arteriosclerosis and senility, the neuropathic constitution, etc., as well as the diathesis to tuberculosis, diseases of the respiratory mucous membranes, syphilitic taints, heart diseases, eye defects, rheumatism, kidney diseases, skin diseases, etc., as well as cases of alcoholism that are apparently inherited and which must be included in this large class of inherited mental or neuropathic diseases, as must also a certain class of mentally and morally explosive persons who find it impossible to control their impulses and animal instincts.

The germ plasm or germ cells are differentiated from the body or some cells very early in the course of development and reside in the ovaries and testes, being, to a degree, out of relation to the body cells and leading a relatively independent existence except for the fluids surrounding them and from which they derive nourishment. This gives rise to *the theory of the continuity of the germ plasm*, which means that they, the sex cells, carry on through all generations the hereditary factors from individual to individual, practically uninfluenced by what may occur in the body at large, so that regardless of such accidents to the body, as for example the loss or mutilation of a limb, or other similar changes, or the acquirement of some special skill in one direction, the germ cells are uninfluenced and carry on from generation to generation only what they originally contained.

They admit that the germ plasm itself possesses all the marvelous potentialities which is necessary to account for the highest development of mankind.

If Weissmann is right in his contention that no acquired characteristics can be transmitted to posterity, then all of the achievements of our education, training and civilization, which have been so rapid in their strides since the invention of the printing press, are completely lost, so far as they affect the innate character of posterity. While all authorities agree with Weissmann that the so-called innate or inborn traits are sure to be transmitted, many authorities believe that the effects of all these acquired characteristics so react on the body and mind and moral nature of human beings that they result in corresponding variations, which have commenced long ago, as a result of these intrinsic forces.

As contrasted with Weissmann's theory the Lamarckian theory insists that structures came into existence or went out of existence by the results of use or disuse.

Some of the great Laws of Eugenics, like the Law of Averages and the Laws of Evolution, have enabled us to preserve what sanity and stability we have.

Abraham Lincoln and many others of the world's notables, who sprang from high average, rugged, hard-headed ancestors, who, like Lincoln's immediate ancestors, had a good lineage generations back and an immediate ancestry that was a pure-bred, hardy and healthy stock, in the sense that their transmitted characteristics were convergent or cumulative in the person of Lincoln. The same may be said of the famous Adams family of Massachusetts, father and son Presidents of the United States. It is interesting to note in this connection, on the authority of Reibmayr, that genius does not carry down the stock and that on the contrary it is a remarkable fact that the male line where there are children rarely extends beyond the third generation.

No generation either of man or animals or plants determines or provides the future of the race, as a small percentage, as a rule, of any species reach maturity and only about one-tenth of those give birth to the next generation. This one-tenth, as Saleeby says, in the long run, make history, and a Kant or a

Spencer dying childless may leave what we call immortal works, but unless they and their class become parents or unless the average parents of *each* generation are rightly chosen or selected, a new and inferior generation may at any time arise, to whom the greatest achievements of past generations are as nothing—"As pearls before swine."

The world may, however, owe much to some of its geniuses whose extraordinary mental abilities may have been, as pointed out by Lambrosa, the expression of epileptic equivalents, or the "degeneration of genius," without the force of which we may not have had the influences of some of our greatest reformers, like the prophet Mahommed, Joan of Arc, and others.

Since the individual is only the product of what is in his father and mother (plus the individual's environment), mating is a matter of vital importance, and it is in this matter that physicians can, by employing the Laws of Eugenics, be of the greatest service to posterity and to those who are wise enough to consult them regarding proper mating. By this practice the physician can, more than any other social agent, help to eliminate inheritance of bad traits and the tendency to many diseases, particularly mental diseases. It has been pointed out that a man or a woman born of diseased parents, being themselves normal (although having the bad inheritance in their bodies as recessive), may by mating with normals who have no such tendency, produce mostly healthy children, and can in the end, in a comparatively few generations, eliminate many diseases. These children and their children by normal matings may have children in whom no trace of the original taint will appear.

In spite of the best mating, we shall for a long time have defectives in our midst. How are we to deal with these defectives, physical, mental and moral, whose propagation of their kind would soon contaminate the race and which indeed is contaminating the race? Race improvement must rest on "selection," good or bad. In other words, a wise process of selection will determine the future welfare

of the race. The fundamental factors in that wise selection or, as it may be called, "artificial selection" would work practically for this desired result—a result on which depends either the glory or the downfall of the republic. Parenthood with the race is everything.

Such environmental factors as are within the province of the State and Nation to modify and control, as well as the educational and religious training and all the surroundings that our civilization has brought, both good and bad, must, according to the consensus of opinion on this subject, influence heredity, as is shown in the familiar cases where vicious environment has caused alcoholism and alcoholism in its turn has caused in successive generations disease, pauperism, insanity and crime. Again the importance of good environmental conditions is emphasized by the fact that the thousands of weaklings have an inherited toxic poison, syphilis, etc. (and even the *fœtus* influenced in utero by these poisons, after the birth of the child and its removal from the tissues and fluids of the diseased mother), tends to immediately rebound in an effort to gain normal character. The same may be said of children born of tuberculous or anæmic and otherwise enfeebled mothers and fathers.

Such a widespread campaign of education of the people as to the truths of heredity and Eugenics and as to the means of race improvement, should be accompanied by plain warnings as to the danger of unfit matings, and at the same time confidential, free medical advice to the poor should be provided for by law, so that those interested would be stimulated and encouraged to discuss this question as widely as possible and to seek counsel and advice from physicians and others competent to counsel and advise them in the matter of the importance of tainted persons marrying none but normals of a pure-bred stock.

We have only to recall case after case in our own experience and to look up some of the thousands of charts that are accessible showing the lamentable consequences of such



unsuitable matings to be impressed that the final elimination of insanity and many other hereditary diseases by the education of this large class of normal recessives in this direction, would prove on our part and on the part of the nation worthy of any effort and expense. In solving the problem we must also have in mind how neuropathic and other tainted stock is developed by bad mating out of an original healthy stock and how even epilepsy, insanity and neuropathic and psychopathic states have been thus developed through a number of generations, notwithstanding Nature is always trying to end or mend by "natural selection," sexual selection—aided by anticipation—a stock that has become degenerate. As illustrating the seeming elimination of even epilepsy and several generations of tainted stock by suitable matings of the normal recessives of that stock, and also as illustrating the development of epilepsy, insanity, neuropathic and psychopathic states in previously healthy stock by matings with tainted stock, the hereditary charts and family histories prepared by F. W. Mott, an eminent English authority, are illuminating and suggestive along the lines of the main point of my paper, that is, some practical, unsensational suggestions that would, if followed, lessen the preventable race impairment that is now admittedly going on.

It is not claimed that the beneficial principles will or can be so rapidly carried out as to produce in a few decades a perfect race of super-men or super-women, or physical or mental giants, but it is insisted that if its great underlying laws are sufficiently understood and seriously considered, that fair-minded men and women will admit that the present investigations and known truths regarding Eugenics justify the full acceptance of certain generalities on this subject, which if properly applied would lead to the immense improvement of the race by better breeding and the elimination of a vast number of preventable mental and other diseases.

## OPEN-AIR LIFE.

J. M. MASTERS, M. D.,

Port Orange, Fla.

The value of pure air in treatment of tuberculosis can not be overestimated. Areteus knew this and advised his patients not to cover their heads while sleeping. Pure air containing a normal amount of oxygen free from foreign substances is essential alike to the well or sick. The thing to be most carefully studied is the conditions under which patients must live to secure pure air; a good deal of misunderstanding exists with the profession and laity as to the best means for supplying fresh air to patients. What is commonly termed open-air treatment means to most persons living outdoors and that pure air can not be obtained except by tent and shack life. Another wrong belief is very prevalent that certain localities or altitudes furnish to patients a superior quality of air. We must remember that the atmosphere is a constantly shifting gaseous volume that is never still: the air in one locality today may be hundreds of miles away tomorrow, and counter air-currents are ever mixing atmosphere from distant localities. A very erroneous opinion is largely entertained that air at high altitudes contains a greater per cent of oxygen than at sea level. This is not true. A very useful series of examinations of air content both as to relative quantity of oxygen and foreign substances was made some fifteen years ago in Philadelphia. Air was secured from all parts of the United States. The amount of oxygen contained in all specimen was almost uniform; that containing the least was collected from Pike's Peak. The purest specimen, containing the least foreign substances, was secured over the Atlantic Ocean one hundred miles off the coast. No doubt the mistaken idea that the higher strata of air contained a greater proportion of oxygen came from its specific gravity, that its lightness would cause it to ascend and accumulate high up in the atmosphere. But we must not forget that all vegetation exhales oxygen and as we ascend

beyond the line of forests and vegetable growth an appreciable lessening of free oxygen is found. Therefore, from the standpoint of securing a greater amount of oxygen, sending patients to high altitudes is a mistake. Another incorrect view is that cold air is purer than warm air. Cold air does not mean pure air; neither does warm air mean impure air. People could not live in cold countries had Nature not provided means for warming the air before it reaches the lungs. Sending tubercular patients to high cold climates overtaxes the mucus membranes of the upper air passages.

Another misunderstanding as to the best quality of air to breathe is that dry air is best, especially for tubercular subjects. To correctly settle this question we need only study the physiology of the upper air passages. The nose was made especially to breathe through; the mucus membrane of the nasal passages is abundantly supplied with serous glands to furnish moisture to dry air that would be highly irritating to the lungs. The best air to breathe is that of a humidity of from seventy-five to eighty per cent.

The question then is: How can tubercular patients best be supplied with normal air of proper humidity and temperature? Does the so-called open-air treatment, as commonly understood and practiced, accomplish this purpose? Unless proper conditions attend outdoor living, and so frequently they do not, much harm is often done the patient. The fact that must never be forgotten is, we are dealing with a disease of a vital organ, and a debilitated patient. Although air may enter the cells of an inflamed lung, but little can pass through the congested mucus tissue into the blood. All conditions that may draw upon the energies of the patients must be avoided. He must be placed under conditions and control that will enable him to live with the least amount of oxygen. Tent and shack life can scarcely be made to meet these requirements. Fresh air must be supplied, but under surroundings that patients receive it without exertion and exposure. It is very

difficult to properly care for and protect patients living in camps.

Treating tuberculosis consists of numerous small details all very important, many of which are overlooked or impossible to meet under camp conditions.

By open-air life we should mean placing the patient in comfortable quarters, free from all exposure, with ventilation so perfect that each breath is new air, surrounded with conveniences that make possible the absolute control of the patient's conduct and the full compliance with the smallest detail of treatment. Simply living outdoors, unaccompanied with other necessities, is a waste of time and has lead to thousands of deaths.

A paradoxical state of mind exists with the public concerning tuberculosis. There has been so much talk of the dreaded great white plague that the public has been filled with fear and consumptives are shunned as lepers. Then with this awfulness of the disease absorbing their minds they attempt to minimize the requirements for prevention and cure of the malady. With many doctors, and practically all the laity, all that is thought necessary is open-air life, eating raw eggs, and drinking plenty of sweet milk, the patient usually taking care of himself as long as his strength enables him to do so.

Treating tuberculosis is one of the most difficult and exacting fields of medicine. Until the profession becomes more familiar with the methods absolutely necessary to combat the disease, and the minds of the people are disabused of the fallacies they are confidently relying upon for relief, but little progress will be made.

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## DIAGNOSIS AND TREATMENT OF MYOCARDITIS.

R. R. NIBLACK, M. D.,

New Smyrna, Fla.

The diagnosis of myocarditis in many cases is made more from inference than definite signs, especially so in acute myocarditis.

The most characteristic signs of myocardial weakness is dilatation of the heart. The

heart is usually but by no means always rapid. Sounds may be clear but usually short and sharp. A galloping rhythm or a pre-systolic beat may be present, and very commonly we hear a soft systolic murmur over the apex or tricuspid area. The second pulmonic sound is accentuated. Arrhythmia present in many cases.

In uninfected diseases, when the symptoms are out of proportion to the severity of the disease, it is presumptive evidence of myocardial weakness. In such cases the symptom complex of restlessness, marked dullness over cardiac area, constriction over chest, precordial pain, vomiting and cyanosis is practically pathognomonic of acute myocarditis.

The symptoms of chronic myocarditis are usually those of gradually developing cardiac weakness, progressively increasing weakness and dysphonia, at first on exertion, later when at rest, finally reaching the stage of orthopœa. Palpitation and precordial pain are frequent symptoms, associated with sudden dilatation of the heart; swelling of abdomen, œdema of feet and legs, diminution in the amount of urine passed; sugar, cyanosis, dilatation of venules, especially over face, and engorgement of larger veins; marked dilatation of heart with arrhythmia and systolic murmur at apex, and enlarged liver.

*Treatment:* Acute myocarditis differs from chronic in treatment, as acute myocarditis is only a temporary condition. In the acute form the aim is to allow the heart muscle to return to its normal state, while in the chronic form this can not be hoped for. Accordingly, even in the mildest form of acute myocarditis rest is the most essential. Keep in bed at least two weeks after all indications of myocardial weakness have subsided. Ice bag to precardium, small blister may be applied over cardiac area. Potassium or sodium iodide in small doses. The use of digitalis is a debatable question, its use depending upon the changes in the heart muscle. Digitalis spurs the heart on and raises the strength of the contraction, but it

does not raise the limit strength. Therefore, when the limit strength is reached and digitalis is used, it drives the heart to over-strain and death. If given, it should be given in small doses. Strychnine and caffeine are useful drugs, but the beneficial or harmful effects are less marked than by digitalis.

To summarize: In acute myocarditis absolute rest in bed, ice bag to precardium, or fly blister, small doses of strychnine, caffeine or digitalis, and bowels well open.

The treatment of chronic myocarditis is similar to the acute, but we can never hope for the heart to return to the normal condition. Therefore the general plan of treatment is rest in bed during the severe stages of failure, purgation, light diet, digitalis or strophanthus in severe cases, graduated exercises. The introduction of strophanthus intravenously gives remarkable results in some cases. Amyl nitrite or sodium nitrite for stenocardial attacks. Even at times venesection has tided over many patients and prolonged their life for some time. Morphine is an excellent drug at times, but dangerous on account of the habit-forming properties.

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## RELATION OF THE PANCREAS TO DIABETES.

H. S. MUNSON, M. D.,  
DeLand, Fla.

The essential feature of diabetes is a disturbance in the carbohydrate metabolism, as a result of which an excessive amount of sugar accumulates in the blood. The factors bringing about this result are not definitely known. Great progress was made when it was discovered that complete extirpation of the pancreas in dogs is invariably followed by diabetes. The conclusion seemed warranted that the pancreas supplied an internal secretion essential to carbohydrate metabolism. Some observers attributed the results of pancreatic extirpation to a disturbance of the nervous mechanism, but since, if the pancreas is excised and a piece is transplanted under the skin, diabetes does not occur, despite the fact that the nerves about the pancreas suffer



the same injury, this conclusion is not warranted.

MacCallum tied off a part of the pancreas from the rest and allowed it to undergo atrophy for a year. At this time the remainder of the pancreas was extirpated and after a transient glycosuria the dog recovered completely. A subsequent removal of the atrophied part caused an intense and persistent glycosuria.

Extirpation of the pancreas is followed by the disappearance of glycogen from the liver and muscles. The pancreatic theory is supported by the observations of Opie, Weichselbaum, Cecil, and others, that the organ more commonly diseased in diabetes is the pancreas. A variety of changes have been discovered, but the islands of Langerhans are most frequently affected.

Allen, in his experiments, found that the removal of nine-tenths of the pancreas produced in dogs a severe and rapidly fatal diabetes. When a somewhat larger portion than one-tenth was preserved, a milder type of diabetes resulted which lasted for some months and then led to the death of the animal. When a still larger fragment was allowed to remain, the dog became potentially diabetic. That is, during starvation or on a meat diet, no sugar was excreted, but sugar was excreted when fed on bread. When a still larger portion of the pancreas was allowed to remain, no sugar was excreted on a meat or on a bread diet, and the animal maintained a fairly normal existence, but if sugar was given, glycosuria appeared. By continued sugar feeding, a permanent diabetes is established, a return to a meat diet failing to remove the sugar from the urine.

These researches prove that diabetes — at least in the experimental animal — is connected with insufficiency of the pancreatic function, which may be brought about abruptly by the removal of nine-tenths of the pancreas, or gradually by exhausting the functional power of the remainder of the organ, when a smaller portion is removed.

Allen applies these facts to man and holds that diabetes must be looked upon as a weak-

ness or exhaustion of the pancreatic function. Allen assigns to the pancreas in carbohydrate metabolism the function of supplying a chemical substance or amboceptor, by means of which the sugar is able to combine with the tissue cells. The amboceptor is secreted by the islands of Langerhans. In its absence the tissues are unable to utilize the sugar that is brought to them.

While the pancreatic theory of diabetes is generally accepted, some hold to the pluriglandular theory, according to which diabetes is due not alone to a disturbance of the pancreas, but also to a disturbance of the various ductless glands, and of the liver. It has been found that glycosuria can be produced by injections of adrenalin and this glycosuria is associated with glycemia, like spontaneous diabetes. The thyroid gland, the hypophysis and the parathyroids have some connection with carbohydrate metabolism.

While the details of the complicated relationship of these various glands of internal secretion to the metabolism of sugar have not all been worked out, the following has been suggested as a working proposition: The liver and muscles are the great storehouses of glycogen. The pancreas, through its internal secretion, stimulates and controls the storing of the hepatic glycogen. The suprarenal secretion has the function of liberating glycogen in response to the needs of the system. The thyroid gland seems to possess an inhibitory influence upon the pancreas, lessening the control of the pancreas over the glycogen retention in the liver. The hypophysis seems to act like the thyroid; it sends inhibitory impulses to the pancreas. The parathyroids on the other hand have an action opposite to that of the thyroids. It is evident that the interlocking relationship of so many organs of carbohydrate metabolism must have some superior control. This is exercised by the sympathetic nervous system.

The work of Allen, however, seems to show that whatever part is played by other glands, the pancreas seems to be the dominating factor in the production of diabetes.

## DIABETIC GANGRENE.

DEAN T. SMITH, M. D.,  
Daytona, Fla.

Diabetes mellitus predisposes its victims to ulcerative and gangrenous conditions. While the cases are rare, they are of frequent enough occurrence to lead the physician to consider the possibility of diabetes in every case of carbuncle, sloughing ulcer or gangrene.

If localized gangrene occurs in a patient suffering from diabetes mellitus it is termed diabetic gangrene. The gangrene may involve any part of the body, but the lower extremity is the part usually affected. I have never seen the condition in any other part.

This type of gangrene is usually easily distinguished from senile, because it is moist while the latter is dry. However, in cases with arteriosclerosis, diabetic gangrene may be dry.

Just why diabetics are more subject to gangrene than others who are equally depleted by disease conditions has not been satisfactorily explained. A number of conditions of tissues results from the diabetes, any one of which might account for the trouble. Da Costa, in his *Modern Surgery*, gives the best discussion of these theories I could find. Much of what I have to say on this point is based on what I found in his book. The presence of sugar in the blood and in the serum from wounds not only lowers the resistance of the tissues to bacterial growth, but makes a good culture medium for bacteria. The following is an interesting point along this line: "J. C. Da Costa and Beardsley demonstrated that diabetes blood serum shows a lowered opsonic index for tubercle bacilli, staphylococci and streptococci." The above theory could account for the frequent occurrence of boils and carbuncles in diabetics. But in the few cases of typical gangrene I have seen, bacterial invasion was not at all active. Another theory is that lack of oxygen in the tissues is responsible. Another,

that nerve degeneration is a factor. From the peculiar localization sometimes observed, it seems probable that the sympathetic of the part is affected. But why a single branch is affected is not explained. Arteriosclerosis is given as a cause. The fact that the condition occurs most frequently in elderly people will strengthen the claim that the condition of the arteries is largely responsible. Probably each of the factors are at times responsible. Da Costa says: "As in senile gangrene, a slight injury is apt to be the exciting cause. In such a case the urine contains sugar and perhaps albumen, but seldom either acetone or diacetic acid. In the other form an injury, perhaps a trivial one, is followed by a rapidly spreading cellulitis which seldom forms pus and which eventuates in moist gangrene. In such cases the urine is apt to contain acetone and diacetic acid, and there is grave danger of coma."

The death of the tissue or part is frequently enough attended by severe neuralgic pains to make one suspicious that gangrene will eventuate if there is localized neuralgia or neuritis in an extremity in a patient suffering from diabetes.

In some cases the gangrene shows little tendency to spread. In others it spreads rapidly.

The presumption is that the patient is treating for the general condition. Any treatment of the gangrene is apt to be unsatisfactory. The local treatment should seek to prevent local infection as much as possible. If a line of demarcation forms it may be wise to help nature in clearing away the dead tissue. Avoid cutting unless it is necessary. If the gangrene is spreading and with no tendency to self-limitation, amputation of the limb becomes a necessity. If the foot is involved, the amputation should be in the lower third of the thigh. In some cases cure will result so far as the gangrene is concerned. In others the traumatism of the seemingly healthy tissue will lead to further gangrene.

## THE TREATMENT OF TUBERCULOSIS OF THE SKIN.

MILTON P. GUY, M. D.,

Daytona Beach, Fla.

The treatment of this form of tuberculosis should begin, as in any other form, by good hygienic surroundings and constitutional measures. The general health should be observed and an anæmic or scrofulous condition corrected as far as possible by proper nourishment and cheerful surroundings. Fresh air, sunshine and easily digested and nourishing food are three cardinal rules of treatment.

Pure fresh air and sunshine are easily obtainable in our climate, but Nature has not dealt with us so generously in regard to food; and good milk rich in butter fat is sometimes hard to procure. The latter when at hand is relished by most people, while the justly celebrated cod-liver oil is quite often repugnant.

### *As to Local Treatment.*

When complete destruction of the affected area with the invading bacilli can be obtained, a cure may be hoped for. This can be done surgically by complete extirpation or the nodules may be destroyed by the actual cautery or by nitrate of silver. The sharp curette in skillful hands is said to cure many cases.

Local caustics are used with much benefit, some of the most important being pyrogallie acid 15 per cent in ointment or collodian.

Salicylic acid 1 dram to ounce of glycerine or vaseline.

Chromic acid 10 grains to ounce.

Lactic acid 50 per cent painted over part has often cured.

Oleate of mercury 3 drams to ounce of zinc ointment is often curative.

The Finsen light and X-ray are now used with a great degree of success and are usually preferred.

Internal medication is believed by many to be beneficial and to hasten a cure.

Arsenicum album, arsenicum iodatum, iodide of potash, calcareo flouricum, nitric

acid, phosphorus and sulphur may be mentioned as beneficial.

While the outlook in tuberculosis of the skin is often discouraging as to time spent in treatment or ultimate recovery, still in a large per cent of cases a cure may be expected and therefore the patient encouraged as to a final cure.

## FEEDING OF THE TUBERCULAR PATIENT.

C. C. BOHANNON, M. D.,

Daytona, Fla.

The diet of a tubercular patient is of as much importance if not more so than fresh air. The most approved diet consists of three regular meals per day of ordinarily good, plain, wholesome, varied mixed food with lunches between consisting of eggs, milk, kumiss and beef juice or broth. The lunches are usually dispensed with when the patient attains his normal weight.

Meat, preferably beef and mutton, especially rare beef, is probably the best food, and at first should be eaten three times a day. Fresh eggs are also important and can be taken raw or cooked up to six a day. Pure milk may be taken in daily quantities of three or four pints, but drunk slowly. It should be taken very slowly on account of the curd which it forms in the stomach and if taken in large quantities will not be acted upon properly by the juice of the stomach. Bread, butter, cheese, vegetables of all sorts, salads and fresh and cooked fruits complete the dietary.

The meals should be chosen with care as to variety, tastefully and appetizingly prepared and served daintily and punctually.

The patient should eat slowly and masticate well, for which his teeth should be put and kept in the best possible condition. He should eat just enough food and the right kind of food to enable him to gain about one or two pounds per week until the normal weight for his age and height is reached, and then just enough to maintain this. Many patients, however, do not gain on this



ordinary diet and can not digest it, but require special diets and extra food.

The best diet in the writer's experience is two to three pounds of beef a day and eaten in the form of rare beefsteak, rare roast beef, rare hamburger steak, raw meat chopped up with onions, celery, green peppers, etc., and raw scraped beef sandwiches. One-half hour before each meal the patient should take one cupful of hot water.

Eggs cooked or raw, plain or in milk, or as an eggnog or as an egg lemonade may be taken.

Milk raw or boiled, hot or cold, in large quantities or small, plain or with the addition of table salt, sodium citrate, lime water, bicarbonate of soda, malted milk, barley water or oatmeal water; one of the prepared foods, carbonated water, a little tea, coffee or brandy, peptonizing or pancreatizing powders or lactic acid bacilli or in the form of buttermilk or kumiss. One must be careful to avoid disturbing the digestion or injuring the kidneys.

### DIET IN CHRONIC BRIGHT'S DISEASE.

VIDA Z. BAERECKE, M. D.,  
DeLand, Fla.

In chronic parenchymatous as well as in chronic interstitial nephritis diet is one of the essential parts of the treatment. All writers agree that the diet should contain merely enough protein to supply the body-needs, at the same time possess the proper caloric value.

The minimum amount of protein required in twenty-four hours is about 80 to 100 grams; it does not matter so much whether that protein is taken in the form of milk, eggs, meat or as vegetable protein. Red meat, so long considered the most dangerous article of food for the nephritic, is no more harmful than white meat, the difference being an addition of blood that makes the color.

*Two ounces meat*, representing about 10 grams protein; *two eggs*, containing 12 grams, and *a quart of milk*, containing 30 to

35 grams, daily would leave a sufficient amount of protein to be supplied by vegetables, cereals and fruits.

The diet must be free from substances that irritate the kidneys, therefore beef extract, potted meats, sausage are prohibited; also condiments, spices, pickles, sharp vegetables and drinks, and alcohol. The latter is allowed in small quantities when a stimulant is needed. Cereals, vegetables, potatoes, fruits, fats and sugar may be safely given. The latter especially is an excellent addition as it has a high caloric value and no nitrogenous waste.

As to tea, coffee and tobacco, all may be allowed, unless they act as cardiac irritants, or cause insomnia.

This mixed diet has, of course, a distinct advantage above the milk diet, and we need only resort to that, or better to the cream-and-milk diet, when our patient is threatened with uremia. Overeating, however, is as great a danger as eating the wrong things; the body weight must be kept up, but not increased.

How about the restriction of fluids in these cases? It is necessary that the permeability of the kidneys to water is determined in every case. If it is good, shown by absence of œdema, the patient should receive enough fluid to bring the output of urine to three pints in the twenty-four hours, to insure good elimination of nitrogenous waste. In the interstitial variety, four pints would be better as the urine is less concentrated in these cases.

A minimum of salt is advocated especially in chronic parenchymatous nephritis, because in many of these cases the kidneys are impermeable to salt, and as nearly every individual consumes many times more salt than is necessary, the excess is retained in the system and with it sufficient water to maintain the proper molecular concentration (Widal's theory of œdema). Two grams sodium chloride is all what is required, that is as much as is contained in one quart milk, and no salt should be added to other food than what is used in bread-making.

In the interstitial type salt restriction is not so essential, but every patient should acquire the habit of using a minimum quantity.

Following are daily menus, giving 80 to 100 grams protein, with caloric value of 2,500 to 3,000 (computed after the tables of Atwater and Bryant, U. S. Department Agriculture) :

<i>Breakfast—</i>	<i>Protein in grams.</i>	<i>Calories.</i>
One Orange .....	1	75
Oatmeal .....	3	66
One Egg .....	6	80
Two Slices Bacon .....	5	170
Bread, 100 grams (3 ounces— 3 slices) .....	9	270
Butter, 1-16 pound .....	1	230
Sugar, 3 teaspoonfuls .....	.	120
Cream, 1 ounce .....	1	30
Coffee .....	.	...
	26	1041

<i>Dinner—</i>		
Potatoes, 2 tablespoonfuls....	2	110
Two Slices Tongue .....	5	100
Cauliflower, 2 tablespoonfuls.	2	30
String Beans, 2 tablespoonfuls	1	20
Pudding { Macaroni, 1 ounce. ....	4	125
{ Milk .....	10	170
{ Egg .....	6	80
Sugar, 2 teaspoonfuls .....	.	80
Butter, 1-16 pound .....	1	230
	31	945

<i>Supper—</i>		
Rice, 2 tablespoonfuls.....	3	112
Bread, 3 slices.....	9	270
Butter, 1-16 pound.....	1	230
Milk, 1 cup .....	10	170
Strawberries, 2 tablespoonfuls	1	80
Sugar, 2 teaspoonfuls .....	.	80
	24	900

Total: 81 grams protein; 2886 calories.

<i>Breakfast—</i>	<i>Protein in grams.</i>	<i>Calories.</i>
Apple .....	1	100
Oatmeal .....	3	66
Bread, 3 ounces—3 slices....	9	270
Two Eggs .....	12	160
Milk, 1-3 quart .....	12	217
Sugar, 2 teaspoonfuls .....	.	80
	37	893

<i>Dinner—</i>		
Potatoes, 2 tablespoonfuls....	2	110
Peas, 2 tablespoonfuls.....	7	120
Asparagus, 2 tablespoonfuls..	2	85
Meat Roast, 1½ ounce—1 slice	7	120
Rice, 2 tablespoonfuls .....	3	112
Sugar, 2 teaspoonfuls .....	.	80
Milk, 1-6 quart .....	12	217
	33	844

<i>Supper—</i>		
Bread, 100 grams—3 slices....	9	270
Butter, 1-16 pound .....	1	230
Milk, 1-3 quart .....	12	217
Prunes, 2 tablespoonfuls .....	1	82
	23	799

Total: 93 grams protein; 2536 calories.

## PROPAGANDA FOR REFORM.

ABSORPTION AND EXCRETION OF MERCURY.  
—It may be regarded as clearly established that, in addition to the kidneys, the stomach may participate in this eliminatory function quite as well as the other portions of the alimentary tract. The occurrence of severe intoxications from the use of mercuric chloride in vaginal douches is likewise recognized. The absorption of mercury through the sound skin has been in dispute. To account for the efficacy of mercurial inunction, the contention has been made that the mercury thus applied is volatilized and absorbed through the lungs in greater part if not entirely. Experiments in the dermatologic laboratories of the Philadelphia Polyclinic leaves little doubt that the skin is an important, perhaps the most important path of absorption of mercury applied by inunction. (*Jour. A. M. A.*, Feb. 9, 1918, p. 392.)

ACETYLSALICYLIC ACID AND PHENYL SALICYLATE INCOMPATIBLE WITH ALKALIES.  
—In the presence of moisture, acetylsalicylic acid is decomposed by magnesium oxide (calcined magnesia), as is also phenyl salicylate (salol). Hence these drugs should not be combined with magnesium oxide in a prescription. (*Jour. A. M. A.*, Feb. 9, 1918, p. 410.)

AMERICAN-MADE ACETYLSALICYLIC ACID.  
At the request of the Council on Pharmacy and Chemistry an examination of the market supply of American-made acetylsalicylic acid has been made in the A. M. A. Chemical Laboratory by P. N. Leech. The investigation shows that there are on the American market, made by American firms, several brands of acetylsalicylic acid that are just as good as, if not better than, the widely advertised Aspirin-Bayer. About a year ago the Council on Pharmacy and Chemistry deleted Aspirin-Bayer from New and Nonofficial Remedies. Since the Bayer aspirin patent expired in February, 1917, thereby making it possible for manufacturers legally to produce and sell acetylsalicylic acid in the United States, the Council established standards for the quality of this unofficial drug. As a result,

the following products have been found to meet these requirements and are included in New and Nonofficial Remedies: Aspirin-L. and F., Acetylsalicylic Acid-Squibb, Acetylsalicylic Acid-Merck, Acetylsalicylic Acid-Milliken, Acetylsalicylic Acid-M. C. W., Acetylsalicylic Acid-Monsanto and Acetylsalicylic Acid-P. W. R. (*Jour. A. M. A.*, April 13, 1918, p. 1097.)

ANTIPNEUMOCOCCUS VACCINE. — The work by Lister in the diamond mines of Kimberley, South Africa, gives promise of a successful method of inoculation against lobar pneumonia. Lister finds that the pneumonia prevalent among the workers in the diamond mines is due mainly to three groups of pneumococci, and that inoculation with a vaccine made from the three groups prevents the occurrence of pneumonia as caused by members of these groups. (*Jour. A. M. A.*, April 20, 1918, p. 1163.)

ANTIPHLOGISTINE.—A. G. Gould, M. D., Plant Physician to the Goodyear Tire and Rubber Company, writes that after corresponding with the physicians in charge, he finds incorrect the claims of the Denver Chemical Manufacturing Company, regarding the use of Antiphlogistine by certain establishments. He asks: "Is there not some way that such exploitation of our large companies can be prevented?" (*Jour. A. M. A.*, Feb. 23, 1918, p. 557.)

BASY BREAD.—This is an asserted obesity cure put out by the Doctors' Essential Food Company, Orange, N. J. The advertising claims are extravagant and typical of other obesity treatment literature. Analyses indicated that in composition Basy Bread was similar to graham bread. Basy Bread sells for \$1 a loaf. Dr. Wiley well sums up the case thus: "There is one way in which Basy Bread will reduce, that is, don't eat any of it nor much of it nor much of any other kind." (*Jour. A. M. A.*, Feb. 9, 1918, p. 407.)

BELL-ANS (Papayans, Bell). — "Are you going to sit there and let the other folks eat up all the good things just because you are afraid to pitch in, when 2 or 3 Bell-Ans taken before and after the meal would enable you

to enjoy your share of all that's coming without a bit of discomfort or distress? Bell-Ans has restored the pleasures of the table to thousands who say: 'I can now eat anything and plenty of it, too.'" The New York *Tribune* comments that such advertisement as this is not limited to the evil effects to the misguided individual who eats lobster and ice cream at midnight and trusts to Bell-Ans to atone for his indiscretion. The most serious effect of such reckless advice is the example which the advertising sets to other advertisers. (*Jour. A. M. A.*, Feb. 23, 1918, p. 557.)

CALCIUM IODIDE IN TUBERCULOSIS. — There appears to be no work to indicate that the intravenous administration of calcium iodide in tuberculosis is of value. It has not been demonstrated that tuberculosis is associated with a deficiency of calcium. On the other hand, experiments demonstrate that the administration of calcium does not change the calcium content of the blood. Furthermore, there is no evidence to warrant the intravenous administration of iodides. (*Jour. A. M. A.*, Feb. 16, 1918, p. 481.)

CAMPHO-PHENIQUE. — The Secretary of the Harvard University Medical School received, from the Campho-Phenique Company of St. Louis, a letter stating that the concern wishes to supply the senior students of all Medical Colleges with samples of Campho-Phenique and Campho-Phenique powder and ointment, and asking the number of students and the name of every student in the graduating class. The Campho-Phenique concern believes in following the old advice, "Catching them young." In 1907, the Council on Pharmacy and Chemistry reported that Campho-Phenique (liquid) was exploited under a false "formula," that it was a solution of camphor and phenol in liquid petrolatum, and that for all practical purposes Campho-Phenique Powder was essentially a camphorated talcum powder containing apparently sufficient phenol and camphor to give the powder an odor. The report of the Council further brought out



that the Campho-Phenique Company was in effect one of the numerous trade names adopted by one James F. Ballard. Mr. Ballard seems to market a number of "patent medicines," for some of which Dr. Ballard has pleaded guilty in the federal courts to making false and fraudulent claims. (*Jour. A. M. A.*, Feb. 9, 1918, p. 408.)

**FELLOWS' SYRUP, AND OTHER PREPARATIONS OF THE HYPOPHOSPHITES.**—An advertisement for Fellows' Syrup reads: "Fellows' Syrup differs from other preparations of the hypophosphites. Leading clinicians in all parts of the world have long recognized this important fact. Have you? To insure results, prescribe the genuine R Syr. Hypophos. Comp. Fellows'. Reject cheap and inefficient substitutes. Reject preparations 'just as good'." In truth, Fellows' Syrup is not like the better preparations of this type, since after standing it contains a muddy looking deposit that any pharmaceutical tyro would be ashamed of. Examination of the literature used in the exploitation of Fellows' Syrup fails to disclose any evidence to show that it has therapeutic value. Not only is there an entire absence of any evidence of its therapeutic value, but there is an abundance of evidence that the hypophosphites are devoid of any such therapeutic effects as they were formerly reputed to have, and that they are, so far as any effect based on their phosphorus content is concerned, singularly inert. As the result of its investigation of the therapeutic effects of the hypophosphites, the Council on Pharmacy and Chemistry concluded: There is no reliable evidence that they exert a physiologic effect; it has not been demonstrated that they influence any pathologic process; they are not "foods." If they are of any use, that use has never been discovered. (*Jour. A. M. A.*, Feb. 16, 1918, p. 478.)

**GUAIODINE.**—Examination of Guaiodine, a preparation of the Intravenous Products Co., Denver, in the A. M. A. Chemical Laboratory shows that, instead of containing free "colloidal" iodine as claimed, the preparation is essentially an iodated fatty oil,

containing only combined iodine. The referee of the Committee on Pharmacology reported to the Council on Pharmacy and Chemistry that equally misleading, in view of the laboratory's findings, are the implied claims that the antiseptic action of Guaiodine corresponds to that of free iodine. Guaiodine is advertised chiefly for the treatment of gonorrhea by means of obviously false claims. The Council declared Guaiodine inadmissible to New and Nonofficial Remedies because of false statements as to composition and action. (*Jour. A. M. A.*, April 6, 1918, p. 1026.)

**HALL'S CATARRH CURE.**—Another victim fails to get the hundred dollars offered in cases in which this preparation failed to effect a cure. The promoters informed its victim that before paying the guarantee, he would have to prove that his case was one of simple catarrh not complicated by any other disease and that he had taken sufficient of the cure. (*Jour. A. M. A.*, April 13, 1918, p. 1113.)

**LUMINAL.**—Chemically, luminal is phenylethylbarbituric acid, and differs from veronal only in that one ethyl group is replaced by a phenyl group. Luminal is claimed to be a useful hypnotic in nervous insomnia and conditions of excitement of the nervous system. (*Jour. A. M. A.*, Feb. 23, 1918, p. 559.)

**MISBRANDED NOSTRUMS.**—The following are some "patent medicines" which the federal authorities held to be sold under false claims: Ascatoo, containing 13 per cent alcohol and some opium. Mexican Oil, containing over 57 per cent alcohol, together with essential oils, glycerin, red pepper, emodin, menthol and a small amount of opium alkaloids. Persil, containing 40 per cent alcohol. Though claimed to contain, in addition, asparagus, parsley, celery, buchu, and juniper berries, it contained no appreciable quantities of celery, buchu, juniper, asparagus or parsley. Dr. D. Kennedy's Favorite Remedy, containing 18 per cent alcohol, nearly 50 per cent sugar, and over 4 per cent potassium acetate, with methyl salicylate, aloes, licorice and oil of sassafras.

Our Standard Remedy, tablets containing rhubarb, senna, scoparius, licorice, red pepper and some ammonia compound with indications of aloes. Dr. King's Throat and Lung Balsam, claimed to relieve coughs and colds and consumptive patients in the last stages of the disease. "White Pine Expectorant" and "White Pine Balsam" (Allan-Pfeiffer Chemical Co.), a syrup containing alkaloid (probably morphin), chloroform, alcohol, benzoic acid and plant extract, but no extract or tar of white pine. California Tuna Tonic Tablets, pills containing iron carbonate and a small quantity of nux vomica alkaloids (strychnin, etc.). Alorine Anti-septic Suppository, containing quinin sulphate, boric acid and tannic acid. St. Joseph's Quick Relief, containing 32 per cent alcohol with Peru balsam, camphor and red pepper. "Andrews' Wine of Life Root or Female Regulator," containing over 14 per cent alcohol, sugar, methyl salicylate and tannin. "Andrews' Wine of Life Root Annex Powders," composed of sodium chloride and sodium bicarbonate, with a small amount of sodium carbonate. Clark Stanley's Snake Oil Liniment, a light mineral oil mixed with about 1 per cent of fatty oil, red pepper and possibly a trace of camphor and turpentine. (*Jour. A. M. A.*, April 20, 1918, p. 1183.)

NEOARSPHENAMINE.—The Federal Trade Commission has granted an importing license to the Diarsenol Company, Inc., 475 Ellicott Square, Buffalo, for neodiarsenol, the Canadian brand of neoarsphenamine. Licenses to manufacture neoarsphenamine have also been issued to The Takamine Laboratories, New York, to the Farbwerke-Hoechst Co., New York, and to the Dermatological Research Laboratories, Philadelphia. The safest and most effective products, provided one has mastered the technique, are the arsphenamines—not the neoarsphenamines. (*Jour. A. M. A.*, April 6, 1918, p. 1027.)

NEUROSINE AND THE ORIGINAL PACKAGE EVIL. — Neurosine advertisements ask that only original bottles of Neurosine be dispensed when physicians prescribe the nostrum. The reason is obvious: the bottle has

the name blown in the glass and thus is an invitation to the patient to purchase more on his own initiative and also to recommend the preparation to his friends. The danger to the public from the self-administration of mixtures of bromides, such as Neurosine, is obvious. Neurosine is said to contain potassium bromid, sodium bromid, ammonium bromid, zinc bromid, extract of lupulin, fluid-extract cascara sagrada, extract of henbane, extract of belladonna, extract of cannabis indica, oil of bitter almond and aromatic elixir. This chemical blunderbuss has been advertised for use in insomnia, hysteria, neuresthenia, migraine, etc., etc. It has also been recommended for children suffering from chorea. In all the years that Neurosine has been exploited to physicians with such remarkable claims, we have never seen a report of a careful clinical study in which the product has been used under the conditions which scientific investigation demands. (*Jour. A. M. A.*, April 27, 1918, p. 1251.)

PHENALGIN AND AMMONOL.—At the time that synthetic chemical drugs were coming into fame and when every manufacturer who launched a new headache mixture claimed to have achieved another triumph in synthetic chemistry, Ammonol and Phenalgin were born and duly christened with chemical formulas. However, one of the first reports of the Council on Pharmacy and Chemistry showed them to be mixtures composed of acetanilid, sodium bicarbonate and ammonium carbonate. Since then the unwarranted claims made for these preparations have been exposed repeatedly, and the danger of the indiscriminate use of headache mixtures pointed out. Despite the exposure of the methods used in exploiting Ammonol and Phenalgin, one finds just as glaringly false statements made in the advertisements of Phenalgin today as were made in its unsavory past. This would seem to indicate either that physicians have short memories or that they are strangely indifferent to the welfare of their patients, to their own reputation, and to the good name of medicine. (*Jour. A. M. A.*, Feb. 2, 1918, p. 337.)

**PYXOL.**—This is a proprietary preparation somewhat similar to the compound solution of cresol of the U. S. Pharmacopeia. In 1915 Pyxol was declared misbranded under the Insecticide Act. (*Jour. A. M. A.*, Feb. 23, 1918, p. 559.)

**SOME NOSTRUMS.**—Continuing its policy of giving the public the facts in regard to worthless, injurious or misleadingly advertised nostrums, the Louisiana State Board of Health has analyzed the following "patent medicines": Dermillo, a skin and complexion nostrum composed of zinc oxid, calcium carbonate, starch and salicylic acid in water, colored and perfumed. Wendell's Ambition Pills, a "great nerve tonic," containing strychnin, ferric oxid, pepper, cinnamon and ginger, and probably a little aloes. Orchard White, a toilet preparation to be mixed with lemon juice, reported to be a mucilage containing bismuth citrate, boric acid, alcohol and gum tragacanth. Exelento Quinine Pomade, a hair preparation found to consist chiefly of petrolatum, some liquid petrolatum, a trace of oil of gaultheria, sulphur, and among other things, a trace of quinin. Sloan's Liniment, which appeared to be composed essentially of oil of turpentine, oil of camphor, oil of sassafras and capsicum. Vick's Vap-O-Rub, which appeared to be a mixture of petrolatum with camphor, menthol and oil of thyme, eucalyptus and turpentine. La Creole Hair Dressing, a perfumed solution containing lead acetate, sulphur and glycerin, alcohol and water. Prescription A2851 for Rheumatism, formerly said to have been known as Eimer and Amend's Rheumatic Remedy, which appeared to be a sherry wine containing 7.5 per cent potassium iodid. (*Jour. A. M. A.* April 6, 1918, p. 1024.)

**UNDULY TOXIC ARSPHENAMIN.**—In view of the reports in current medical literature of untoward results from the use of arspenamin and neoarsphenamin, Dr. G. W. McCoy, Director of the U. S. Hygienic Laboratory, Washington, D. C., requests that samples of any lot of these arsenicals which have shown undue toxicity be forwarded to the Hygienic

Laboratory for examination. (*Jour. A. M. A.*, April 13, 1918, p. 1110.)

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ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1917. Cloth. Price, postpaid, 50 cents. Pp. 169. Chicago: American Medical Association, 1918.

This volume contains the reports of the Council which were adopted and authorized for publication during 1917. It includes reports of the Council previously published in *The Journal of the American Medical Association* and also reports which, because of their highly technical character or of their lesser importance, were not published in *The Journal*.

In this volume the Council discusses the articles which were examined and found to be in conflict with the rules for admission to New and Nonofficial Remedies. Among these reports are discussions of such widely advertised proprietaries as Corpora Lutea (Soluble Extract), Wheeler's Tissue Phosphates, The Russell Emulsion and The Russell Prepared Green Bone, Trimethol, Eskay's Neuro Phosphates, K-Y Lubricating Jelly, Ziratol, Hepatico Tablets, Hemo-Therapin, Venosal, Surgodine and Kalak Water. A report on Iodeol and Iodagol covers fifty-one pages and illustrates the exhaustive investigation which the Council is often obliged to make of proprietary articles.

Similarly illustrative of the Council's thoroughness is the clinical study of Biniodol, a solution of mercuric iodid in oil, and the investigation of Secretin-Beveridge, made for the Council by the physiologist, Professor Carlson, of the University of Chicago. The volume also contains reports which explain why certain preparations, such as Alcresta Ipecac tablets, the German-made biologic products and antistaphylococcus serum, which were described in the last edition of New and Nonofficial Remedies, are not contained in the current 1918 edition. Those who wish to be informed in regard to proprietary remedies should have both the annual Council Reports and New and Nonofficial Remedies.



APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.

....., 191.....

Sir :

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....  
.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....  
.....
4. When and where were you naturalized? (For applicants of alien birth only.).....  
.....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....  
.....
10. If either parent or brother or sister has died, state cause and age in each case:.....  
.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....  
.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc.:.....  
.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates: .....  
.....
16. With what ancient or modern languages or branches of science are you acquainted?.....  
.....

---

\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.

17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result : \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.

## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or P. O. Box 136, Jacksonville, Fla., U. S. A.

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## THE SURGEON GENERAL OF THE ARMY.

With the announcement from Washington that Major General William C. Gorgas will reach the retiring age on October 3d of the present year, it is only natural that speculation would at once become rife as to who is likely to be nominated to succeed him as Surgeon General of the Army. It would seem to THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, representing as it does the organized profession of this state, that *The Southern Medical Journal* has hit the nail squarely on the head under the editorial caption, "Surgeon General Gorgas is Sixty-Three Years Young." It should put at rest for all time the possibility of any other nomination being made, provided, of course, General Gorgas is willing to continue in active service. This unfortunate possibility has to be considered, and is reflected in a recent issue of the *Army and Navy Register*, where it is stated: "There has been some intimation that General Gorgas does not desire to continue in active service." That this worthy and honored member of the medical profession and of the Medical Corps of the United States Army is entitled to rest, no one will deny, whether or not the stress of the times will permit him to avail himself of this well-earned rest is, however, a matter for the Nation to decide. We believe that General Gorgas even in the approaching sunset of his life will be willing to make additional sacrifice, and continue to serve the Nation, aye the world, if he is called upon to do so. His retirement at this time would be little short of a national calamity—and why? It may be that to few men come the opportunities that have come into the life of General Gorgas. The stamping out of yellow fever in Havana, the sanitation of the Canal Zone to a point that made possible the greatest engineering feat in the history of the world, demonstrating at the same time that the white man may live in the tropics with impunity, provided he be protected from the ravages of certain tropical diseases, the con-

**Next Meeting — Miami — May, 1919**



trol of that awful epidemic of septic pneumonia in South Africa, any one of these would be sufficient to place on the immortal role of honor the name of Gorgas, and it demonstrates beyond a doubt that if great opportunities have come into the life of this man, opportunities that come into the lives of few if any, that he has in each and every instance proven himself capable of grasping the opportunity, and not only in each instance place his name on the immortal role of honor, but in each instance to do a great deed of glory in the interests of humanity. And then came another grand opportunity to further demonstrate the possible achievements of the present Surgeon General of the Army.

We entered the dreadful holocaust of the world and to him was intrusted the immense task of building up, from practically nothing, an immense organization to take care of the sick and wounded that are already coming from the battlefields of Europe, and that are to keep on coming in increasing numbers. Without throwing any disparagement upon any other branch of the service, is there a department that is any more thoroughly organized today, or that gives better promise of standing the tests of efficiency that are to come, than the Medical Department of the Army? These are the reasons why we state that the retirement of General Gorgas at this time would be a national calamity, and these are the reasons why we now advocate that a memorial from the medical profession of the United States of America be prepared and sent to General Gorgas urging him to continue as the active head of the Medical Department of the United States Army. As *The Southern Medical Journal* states in the editorial previously referred to: "Millions of mothers and fathers and other relatives and friends of our soldiers thank God every day that General Gorgas is directing the army of doctors who are fighting diseases that are as dangerous and that are as insidious enemies to mankind as the Huns. They feel comforted every day on realizing that

Gorgas is safeguarding the health and lives of their boys."

That General Gorgas will be the presidential choice for the next Surgeon General of the Army, providing he is willing to continue on active duty, there is no doubt; that he will be willing to make this sacrifice and accept further responsibilities, if the matter is placed clearly before him, is also a matter of certainty. Let the medical profession of this country speak in no uncertain manner, let it be known that organized medicine, while recognizing and appreciating the fact that he is entitled to retirement, joins with the millions of Americans having kith and kin on the European battlefields in appealing to him not to relinquish the rudder at this crucial moment in the history of the world.

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#### AN IMPERATIVE APPEAL FOR MEDICAL OFFICERS.

An urgent and imperative appeal has just been issued by the Surgeon General of the United States Army, for doctors for the Medical Reserve Corps.

There are today 15,174 officers of the Medical Reserve Corps on active duty and the Medical Department has reached the limit of medical officers at the present time available for assignment. With these facts before the medical profession of this country, we believe that every doctor who is physically qualified for service between the age of twenty-one and fifty-five years, will come forward now and apply for a commission in the Medical Reserve Corps.

The Surgeon General says: "So far the United States has been involved only in the preparatory phase of this war. We are now about to enter upon the active or fighting phase, which will make enormous demands upon the resources of the country." The conservation of these resources, especially that of man-power, depends entirely upon an adequate medical service.

Drafts of men will continually follow drafts, each of which will require its proportionate number of medical officers and

there are at this time on the available list of the Medical Reserve Corps an insufficient number to meet the demands of these drafts.

The real necessity for the complete mobilization of the entire profession is imperative. It is not a question of a few hundred men volunteering for service, but of the mobilization of the profession for the conservation of the resources of this country. Let every doctor who reads this editorial and appeal from the Surgeon General, which appeal is based upon dire necessity, act promptly and present his application for a commission in the Medical Reserve Corps at the nearest Medical Examining Board. If you are not informed of the location of your Board, the Editor of this journal will advise you.

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### OUR COUNTRY'S CALL.

When our country entered the war the American Medical Association placed its services at the disposal of the Government: its entire machinery, its publication and its total resources—the state and county societies with their 81,000 members—for the purpose of organizing the medical profession for the war. To previous calls the profession has responded splendidly. We are confident that the same ready response will be made to this new call for 5,000 additional medical officers. The matter is considered in greater detail in the report of the action of the War Committee of the Association elsewhere in this issue. No one can prophesy what the duration of the war will be; it may be three years, it may be five years; it may demand three million or five million fighting men. But whatever may be the needs to secure victory, they will be supplied. And the medical profession will do its part. In Great Britain and in France the demands required drafting of all able-bodied men—even those past middle life; and this included the medical profession. While a similar draft on the manhood of this country may have to be made, we do not believe that it will be necessary to include the medical profession, for physicians will do voluntarily whatever they

are called on to do. However, the time has come for deeds, not words; for action, not promises; for accomplishment, not prophecy. The time has come for every medical man under 55 years of age, who is physically qualified, to consider seriously for himself the question of his duty to his Government. In doing this, each one must realize that practically all who have thus far volunteered have done so at a sacrifice; in some instances the sacrifice has been small; in others, great. Patriotism and one's sense of duty to one's country have been the motives that have prompted the action of those who have joined the Medical Reserve Corps. This has been especially true when action meant sacrifice. That same spirit must and will prevail now.—*Jour. A. M. A.*

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### THE REGULAR MEDICAL CORPS— AN OPPORTUNITY

This is a call to the young medical men of America, to the men not yet established and who are seeking a career. The United States Army Medical Corps has eleven hundred vacancies; officers for six hundred and fifty of these are urgently needed now. It is not a sacrifice—the men who can answer this call are in any event practically within the draft age. It is a call to them to choose the Army medical service, not as a temporary vocation, but as a career. Today probably every young physician gives some thought to this choice. Few, however, consider the opportunity with a full knowledge of its advantages.

The medical officer is not only a physician, but a soldier. He has a double function and a double responsibility. The history of our Army medical department is full of examples of men who have fulfilled their responsibilities gloriously. The organization to which the young men are called is one of magnificent traditions, of scientific accomplishment, of transcendent present importance. It offers a position of regular employment, of fixed equable income, of steadily increasing ability, importance and emolu-

ment, of opportunity for individual study and recognition. The requirements for admission and the training of the men in the corps, the rank as an officer, insure a most desirable social atmosphere. There is association with well educated, scientific, progressive men and an absence of the petty social jealousies of civil life. The man who is personally fit can go far and achieve much.

The essential requirements are: (1) citizenship, (2) age between 22 and 32 years, (3) graduation from a well-organized medical school, (4) one year's hospital internship, and (5) good moral character and habits. Applicants must pass an examination not difficult for men who can meet the other requirements. If successful they receive a three months' training course with full pay and allowances.

This is a call first, to men who are not now in the Medical Reserve Corps, and second, to the younger Medical Reserve Corps officers. The first class have not done their duty by themselves or by their country. The second class have shown their patriotism and are no doubt already in the service or completing internships and awaiting call. They have been permitted to "sample the goods before purchasing." To them especially the service should appeal as a career. They too may make application for examination and transfer to the Regular Medical Corps. The Army and the nation need these men now. It does not ask of them the tremendous sacrifices made by the older men who have given up their homes, families, incomes, and perhaps their careers; it offers an established income and an enviable position.

Young men, this is your opportunity; seize it!—*Jour. A. M. A.*

OUR HONOR ROLL.

Our Honor Roll as published below now constitutes a grand total of one hundred and forty-four physicians. They are divided in the services as follows: Medical Corps—Lieutenant Colonel, 1; Medical Corps, National Army—Lieutenant Colonel, 1; Medi-

cal Reserve Corps—Majors, 14; Captains, 29; 1st Lieutenants, 95; total, 140. United States Navy—Passed Assistant Surgeons, 2; Assistant Surgeons, 4; total, 6. National Guard United States (Fla.)—Majors, 3; Captain, 1; 1st Lieutenants, 4; total, 8.

MEDICAL CORPS, U. S. ARMY.

*Home Address.*

Lieut.-Colonel Joseph Y. Porter.....Key West

MEDICAL CORPS, NATIONAL ARMY.

Lieut.Colonel Raymond C. Turck.....Jacksonville

MEDICAL RESERVE CORPS.

Major Frank E. Artaud.....Key West

Major M. H. Axline.....St. Petersburg

Major John E. Boyd.....Jacksonville

Major Frederick G. Barfield.....Jacksonville

Major Chauncey L. Chase.....Fort Dade

Major Stanley Erwin.....Jacksonville

Major James B. Griffin.....St. Augustine

Major H. H. Harris.....Jacksonville

Major Graham E. Henson.....Jacksonville

Major Frederick E. Jenkins.....Palatka

Major Frank R. Maura.....Ojus

Major Lucien B. Mitchell.....Tampa

Major Harry Peyton.....Jacksonville

Major George A. Plummer.....Key West

Captain A. E. Acker.....Jacksonville

Captain E. G. Birge.....Jacksonville

Captain H. O. Black.....Jacksonville

Captain Andrew R. Bond.....Tampa

Captain O. L. Callahan.....Mt. Dora

Captain T. Z. Cason.....Jacksonville

Captain Lester J. Efrd.....Tampa

Captain Albert H. Freeman.....Starke

Captain Julian Gammon.....Jacksonville

Captain J. Halton.....Sarasota

Captain Henry Hanson.....Jacksonville

Captain Maurice E. Heck.....St. Augustine

Captain Samuel G. Hollingsworth.....Bradentown

Captain Owen H. Kenan.....Palm Beach

Captain S. M. R. Kennedy.....Pensacola

Captain William W. Mills.....Miami

Captain William B. Moon.....Lakeland

Captain Frederick C. Moor.....Tallahassee

Captain John MacDiarmid.....DeLand

Captain R. B. McLaws.....Tampa

Captain D. W. McMillan.....Pensacola

Captain John D. McRae.....Tampa

Captain Thomas A. Neal.....Sanford

Captain James B. Parramore.....Jacksonville

Captain James D. Pasco.....Jacksonville

Captain J. Y. Porter, Jr.....Key West

Captain G. M. Randall.....

Captain M. B. Swift.....Orlando

Captain Harry F. Watt.....Ocala

1st Lieut. Daniel M. Adams.....Panama City

1st Lieut. Allen M. Ames.....Pensacola

1st Lieut. C. A. Andrews.....Tampa

1st Lieut. Harold M. Beardall.....Orlando

1st Lieut. Henry P. Bevis.....Arcadia

1st Lieut. James H. Bickerstaff.....Pensacola

1st Lieut. John B. Black.....Jacksonville

1st Lieut. Everard Blackshear.....Citra

1st Lieut. Louis B. Bouchelle.....DeLand

1st Lieut. John T. Bradshaw.....San Antonio

1st Lieut. Percy H. Brigham.....Branford

1st Lieut. Herbert L. Bryans.....Pensacola



1st Lieut. B. A. Burks ..... Titusville  
 1st Lieut. Fay A. Cameron ..... Tampa  
 1st Lieut. Chauncey L. Chase ..... Fort Dade  
 1st Lieut. Joseph H. Chiles ..... Cleremont  
 1st Lieut. William A. Clark ..... Pine Barren  
 1st Lieut. J. S. Coker ..... Gardner  
 1st Lieut. Henry B. Cordes ..... Jacksonville  
 1st Lieut. Charles S. Cooper ..... St. Cloud  
 1st Lieut. Wallace P. Crigler ..... Ocala  
 1st Lieut. T. G. Croft ..... Jacksonville  
 1st Lieut. Clinton W. D'Alemberte ..... Pensacola  
 1st Lieut. James S. Davidson ..... Clearwater  
 1st Lieut. Kenneth McC. Davis ..... Westbay  
 1st Lieut. Gaston Day ..... Jacksonville  
 1st Lieut. L. B. Dickerson ..... Clearwater  
 1st Lieut. George W. Dupree ..... Blue Creek  
 1st Lieut. William T. Elmore ..... Gainesville  
 1st Lieut. Orin O. Feaster ..... Mulberry  
 1st Lieut. Nacy L. Gachet ..... Century  
 1st Lieut. Claude V. Gautier ..... Passagrille  
 1st Lieut. Hugh St. C. Geiger ..... Kissimmee  
 1st Lieut. H. M. Ginsberg ..... Pensacola  
 1st Lieut. Paul Goss ..... Mulberry  
 1st Lieut. O. F. Green ..... Mayo  
 1st Lieut. John D. Griffin ..... Lakeland  
 1st Lieut. G. H. Gwynn, Jr. .... Tallahassee  
 1st Lieut. Humphrey Gwynn ..... Tallahassee  
 1st Lieut. J. H. Hall ..... Sopchoppy  
 1st Lieut. John Halliday ..... Tampa  
 1st Lieut. Drew R. Handley ..... Jacksonville  
 1st Lieut. MacMiller Harrison ..... Palmetto  
 1st Lieut. John R. Hereford ..... Fort Dade  
 1st Lieut. Frank P. Hixon ..... Pensacola  
 1st Lieut. John C. Holley ..... Pace  
 1st Lieut. H. F. Horne ..... Jacksonville  
 1st Lieut. Roy Howe ..... Daytona  
 1st Lieut. A. L. Izlar ..... Ocala  
 1st Lieut. Edward Jelks ..... Jacksonville  
 1st Lieut. Charles L. Jennings ..... Jacksonville  
 1st Lieut. J. K. Johnston ..... Tallahassee  
 1st Lieut. Charles L. Kennon ..... Jacksonville  
 1st Lieut. Alpheus C. Koon ..... Jacksonville  
 1st Lieut. William J. Lancaster ..... Tampa  
 1st Lieut. Richard Leffers ..... Lakeland  
 1st Lieut. Milford Levy ..... Tallahassee  
 1st Lieut. John P. Long ..... Lake City  
 1st Lieut. John W. McClane ..... St. Petersburg  
 1st Lieut. George S. McClellan ..... Wellborn  
 1st Lieut. James R. McEachren ..... Monticello  
 1st Lieut. Harry B. McEuen ..... Quincy  
 1st Lieut. William G. McKay ..... Jacksonville  
 1st Lieut. Albert C. McKenzie ..... Jacksonville  
 1st Lieut. Earle H. McRae ..... Tampa  
 1st Lieut. H. R. Mills ..... Tampa  
 1st Lieut. George M. Mitchell ..... Jacksonville  
 1st Lieut. Joseph A. Mixon ..... Pensacola  
 1st Lieut. H. P. Newman ..... Bartow  
 1st Lieut. John A. Newnham ..... Cleremont  
 1st Lieut. John K. Norwood ..... Jacksonville  
 1st Lieut. Bascom H. Palmer ..... Tampa  
 1st Lieut. Henry E. Parnell ..... Fort Myers  
 1st Lieut. Archie R. Parrott ..... Jacksonville  
 1st Lieut. James L. Pennington ..... Fountain  
 1st Lieut. J. O. Philips ..... Worthington Springs  
 1st Lieut. William H. Pickett ..... Gainesville  
 1st Lieut. Harper L. Proctor ..... Jacksonville  
 1st Lieut. Marion E. Quina ..... Pensacola  
 1st Lieut. Shaler A. Richardson ..... Jacksonville  
 1st Lieut. Dwight M. Rivers ..... Lake City  
 1st Lieut. E. T. Sellers ..... Jacksonville  
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1st Lieut. Baldwin S. Stutts ..... Port St. Joe  
 1st Lieut. G. C. Tillman ..... Gainesville  
 1st Lieut. W. J. Vinson ..... Tarpon Springs  
 1st Lieut. Harry C. VonDahm ..... Jacksonville  
 1st Lieut. Adam C. Walkup ..... McIntosh  
 1st Lieut. Archie Watson ..... Live Oak  
 1st Lieut. B. L. Whitten ..... Fort Pierce  
 1st Lieut. John M. Whitfield ..... Malone  
 1st Lieut. William E. Whitlock ..... Fort White  
 1st Lieut. Charlton C. Whittle ..... Nocatee  
 1st Lieut. Daniel B. Williams ..... Lake City  
 1st Lieut. Albert H. Wilhienson ..... Jacksonville

## THE NAVY.

Passed Assistant Surgeon W. P. Dey ..... Jacksonville  
 Assistant Surgeon Thomas S. Field ..... Jacksonville  
 Assistant Surgeon Boyd Gilbert ..... Pensacola  
 Assistant Surgeon R. P. Henderson ..... Tampa  
 Passed Asst. Surgeon J. Knox Simpson, Jacksonville  
 Assistant Surgeon D. C. Thompson ..... Pensacola

## NATIONAL GUARD UNITED STATES (FLA.).

Major Lorin Green ..... Jacksonville  
 Major Ralph Green ..... Jacksonville  
 Major James H. Livingston ..... Jacksonville  
 Captain W. J. Buck ..... Gainesville  
 1st Lieut. Daniel C. Campbell ..... Marianna  
 1st Lieut. John R. Hawkins ..... Williston  
 1st Lieut. Z. V. Johnson ..... Milton  
 1st Lieut. J. M. Mitchell ..... Millville

## LITTLE CHILDREN DEPRIVED OF MILK.

That babies and little children are directly affected by the decreased sales of milk reported by dealers in American cities is illustrated by findings for Baltimore made public today by the Children's Bureau of the U. S. Department of Labor.

Of 156 Baltimore children between two and seven years of age, only 29 per cent are now having fresh milk to drink as against 60 per cent a year ago. And only 20, or less than 3 per cent of the children studied, are having as much as three cups a day. With the babies under two the Children's Bureau says the situation is a little less serious. Apparently their needs are more generally understood than the needs of the child over two.

The number of families in this group who are buying no fresh milk at all has risen from 37 a year ago to 107, or 29 per cent of those from whom information was secured, and these 107 families include one-fourth of all the children under seven. At the same time, the total daily purchase of canned milk by

the families studied has increased from 25.5 cans to 84 cans.

Most serious, according to the Children's Bureau, is the general substitution in the children's diet of tea and coffee. Of the 575 children who are not drinking milk, 64 per cent have definitely substituted tea and coffee, and 24 per cent are "sharing the family diet" which may or may not include tea or coffee, or milk in other foods.

While the group of families studied is small, the Bureau offers the findings as fairly representative since the information was secured and transmitted to the Children's Bureau by school nurses of the Baltimore Department of Health and by nurses of the Instructive Visiting Nurse Association and the Babies' Milk Fund of Baltimore from all families they visited during a certain short period, provided (1) there were at least two children under seven years of age; (2) the family had been in Baltimore at least a year; (3) no tubercular patient was living in the family.

Various incomes are reported but the changes in the amount of milk purchased are not unlike in the different earnings groups. Some mothers seem to realize that milk must be provided for their children at whatever sacrifice; others who can better afford to buy milk do not understand its importance and let their children go without it. The foreign-born mothers, although their incomes are slightly lower than the incomes of the native white mothers, have more generally than any other group continued to buy milk. Almost half of the foreign-born mothers have either continued the amount purchased last year or increased it, and only one in ten of the foreign mothers (as against one in three of the other mothers) are now buying no milk at all.

The Children's Bureau states: "Taking a pint and a half of fresh milk as the desirable daily allowance for the average child, these 756 children were having last year on an average only 40 per cent of what they should have had; this year their daily average has dwindled to 14.4 per cent of this allowance.

"The work of Children's Year should emphasize in every community the importance of fresh milk in the diet of young children. Without proper nourishment children can not keep well and free from physical defects, and a campaign of education on the feeding of children is an essential part of the saving of 100,000 lives during the second year of the war."

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### THE REHABILITATION OF DISABLED SOLDIERS.

The vocational and educational problems involved in the rehabilitation of disabled soldiers and sailors are analyzed and discussed by the Federal Board for Vocational Education in Senate Document 167, just published under the title "Rehabilitation of Disabled Soldiers and Sailors—Training of Teachers for Occupational Therapy."

Emphasis is placed on the immediate and pressing demand for the training of teachers of occupational therapy to take care of the handicapped men on their return from France. It is estimated that for every 1,000,000 men overseas, a minimum of 1,200 teachers will be needed. What must be the qualifications of these teachers in view of the experience of the belligerent countries; how they may be trained; what problems are to be met; and how they are to be met in the course of vocational rehabilitation; the social and economic aspects of rehabilitation; and the need for a national system for the rehabilitation of the maimed and crippled in industry as well as in war, are the main topics of the bulletin. The document is written by Elizabeth G. Upham, under the direction of Charles H. Winslow, assistant director for research of the Federal board.

The emergency program outlined in the report is summarized as follows:

The returned disabled men are divided into four classes: (1) those who are permanently invalided; (2) those who are able to work, but can not engage in competitive occupations; (3) those who must learn new occupations in the light of their handicaps;

(4) those who are able to return to their former occupations. About 80 per cent of all the disabled fall into the fourth group, and about 20 per cent into the third group. The first two groups are relatively small.

For group 1 the treatment prescribed is "invalid occupations," which are occupations that help pass the time and save the patient from brooding. For group 2, those who will in all probability be unable to compete in any line of work, simple occupations are prescribed to be carried on under the guidance of occupational therapists. Such occupations as wicker furniture-making, chair-caning, toy-making and semi-trades, will be taught these men.

For the 20 per cent who must learn new occupations a more elaborate course of rehabilitation is suggested. This will include simple occupations such as are taught to the men of the second group, followed by courses in general education wherever necessary, and followed in turn by prevocational education, that is to say, elementary vocational education; and, lastly, by vocational education in whatever line is best adapted to the qualifications and handicap of the man.

A similar curriculum is proposed for the 80 per cent who will probably be able to return to their old occupations. Under the lead of the occupational therapist the patient will be gradually taught simple occupations, his general education will be "brushed up" and the deficiencies supplied, and he will be reeducated so as to resume his former trade in spite of his handicap.

The Federal board presents in this bulletin an outline of an emergency course covering eight weeks for the training of teachers to handle all four groups of disabled men. It is expected that a fraction of the disabled men themselves will serve as instructors. Nurses and teachers of arts and crafts will be available for the invalid occupation work; trained and selected women of education with previous experience in the arts, crafts and the "semitrades" will be drawn on to teach simple occupations to group 2. In addition

to these, there will be need in groups 3 and 4 of vocational teachers, preferably men, and men and women teachers, in general education subjects, instructors in manual training, commercial subjects, mechanical drawing, drafting, etc. Teachers of each group should have had practical experience in hospitals or institutions, and it is recommended that teachers in groups 3 and 4 should have experience in the same line of work in the military hospitals of Canada.

That every dollar invested by the Government in the vocational rehabilitation of disabled soldiers and sailors will bring handsome returns in national efficiency is maintained in the report. "If the war should finally end in economic exhaustion," says the report, "that Nation will ultimately triumph which is best able to use over again her men. It is claimed that Germany uses 85 to 90 per cent of her disabled men back of the lines, and that the majority of the remaining 10 to 15 per cent are entirely self-supporting. Belgium, whose depletion has been the greatest, was the first nation successfully to use over again her men. Not only has the large Belgium reeducation center of Port Villez been self-supporting, but in addition it has paid back to the Belgian Government the entire capital cost of installation \* \* \*.

"Economic necessity has made possible the results achieved in Belgium. For the other nations not so hard pressed the rehabilitation of the disabled and the strengthening of the vitality of the civil population may be an important and perhaps a determining point in their economic future \* \* \*. It is certain that our own economic future depends to a large extent upon the rehabilitation of those disabled both in war and industry."

The bulletin discusses at length the possibilities of development of occupational therapy and the equipment needed for all the groups described. Suggested blanks for keeping the records in the curative workshops and for hospital registration are included.



## WEIGH YOUR CHILD FOR THE GOVERNMENT.

The instruction for carrying out the Weighing and Measuring Test of American children under five years of age were sent today by the Child Welfare Department of the Woman's Committee of the Council of National Defense to its State and local child-welfare chairmen who will be responsible for the test in each community. The record cards will follow after word is received of the exact number required by each committee.

This test is the first feature of Children's Year which begins on April 6th. The plans for Children's Year prepared by the Children's Bureau of the U. S. Department of Labor include activities designed to protect all children from the special dangers of war time and to save the lives of 100,000 little children before April 6, 1919.

Many of the physical defects which caused the rejection of one-third of the men coming up for examination in the first draft are believed to date from some slight trouble neglected in early childhood. And the Children's Bureau emphasizes the fact that a higher standard of physical fitness in the rising generation can be assured only by greater attention to the physical condition of children.

According to the Bureau, height and weight and their relation to each other are a rough index of a young child's health and development. For instance, when a child is strikingly below the average weight for his height or is strikingly small for his age, it indicates that expert advice about diet and daily care is needed. In so far as the test makes it plain to parents that the physical condition of their children needs special attention, and in so far as it leads to community provision for public-health nurses and consultation centers for babies and young children, to a safeguarding of the milk supply, and to other measures for the protection of children, it will aid in conserving their health and in reaching the goal of 100,000 lives saved during Children's Year.

The record card which the Children's Bureau has prepared for this test gives a table of average heights and weights for boys and girls at birth, at every month of age from the 6th to the 48th and at every year from the 5th to the 16th. One-half of the card will be retained by the parents. It includes the table of heights and weights and has blanks for subsequent records so that parents can watch the child's growth; for while a single examination is valuable a series of examinations is far more valuable.

The other half of the card provides also for recording the height and weight of the child at the time of the national test. It will be used by the local committee in analyzing the facts about its own community and then it will be forwarded to the Children's Bureau at Washington.

Parents who wish to enter their children in the national test should communicate with the local chairman of the child-welfare committee of their State Council of National Defense, or if no such chairman has yet been appointed, with the county or State child-welfare chairman of the council. Local chairmen who have not received instructions about the test or the detailed program of which the test is the first feature should communicate at once with the child-welfare chairman of their State Council of Defense.

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## SUGAR IN WAR-TIME.

During recent months, many physicians have been asked regarding the possible effects of the various newly imposed or proposed dietary restrictions or innovations on the health of the individual. Despite the widespread acquiescence of our population in the dictates of the national and state food administrations, there is not unnaturally a frequent final appeal to the members of the medical profession for approval of such changes as have been proposed in the interest of the movement to help win the war. Among other plans for conservation, a reduction in the use of sugar has been urgently requested and, indeed, made inevitable at times when

local shortage has curtailed the available supply so that the customary quota is not forthcoming. A summary compiled for the War Emergency Food Survey Section of the Bureau of Markets<sup>1</sup> furnishes facts that will enable us to draw conclusions more definite than those permitted by vague generalizations from intangible sources. The most pertinent information is that respecting the actual use of sugar in the United States in recent years. The amount consumed in 1917 was approximately 9,100,000,000 pounds, or 88.3 pounds per capita. In 1916 it amounted to 8,300,000,000, or 84.7 pounds per capita. It is thus apparent that if these statistics are correct there has been some increase in the consumption of sugar.

Eighty-eight pounds of sugar per capita used each year represent about 110 gm. (nearly 4 ounces) per day for every man, woman and child in this country. Expressed in terms of food fuel units this is equivalent to 440 calories, a not inconsiderable portion of the daily energy needs of an adult man. The sugar of the daily-diet consumed in the measure indicated by the government statistics would furnish one-seventh of the food fuel where 3,000 calories are required, and even a larger proportion where the daily energy requirement is put on a lower basis. Four ounces of sugar, as the accusation now stands, is the calorific equivalent of two-thirds of a quart of good milk or of eight slices of bread approximating one-third of a pound.

When it is recalled that this great per capita consumption of sugar is largely a phenomenon of recent years and the result of the development of an industry whereby the price of the product has been lowered, the necessity for the inclusion of this carbohydrate up to one-seventh or even one-fifth of the daily energy requirement in the diet will obviously be questioned. Sugar is primarily used for its flavor rather than its fuel value. One American student of nutrition has even

gone so far as to question the physiologic wisdom of the modern increased consumption of sugar. Thus Sherman<sup>2</sup> writes:

"The cheapening of a staple article of food, which is almost universally popular and which, like the refined sugar of commerce, is of uniform and well-known composition and practically free from danger of adulteration or harmful deterioration, would be a source of great satisfaction but for the fact that refined sugar constitutes an extreme case of a one-sided food, its sole nutritive function being to serve as fuel so that, as the energy requirement of the body is met to a larger and larger extent by the consumption of refined sugar there is a constantly increasing danger of unbalancing the diet and making it deficient in some of the substances which are needed for the building and repair of body tissue and for the regulation of physiological processes."

From a practical standpoint it is pointed out in a government bulletin<sup>3</sup> that in the American cuisine sugar is used with too many kinds of food, with a consequent loss of variety and piquancy of flavor in the different dishes. The nutty flavor of grains and the natural taste of mild fruits are very often concealed by the addition of large quantities of sugar.

Sugar is well utilized in the human organism; from the standpoint of cost its food value is very high, and its popularity need not be debated. But there is no consideration of nutrition that seriously demands so large an inclusion of sugar in the diet or forbids considerable reduction in its use, especially when the best interests of the civilized world demand it.—*Jour. A. M. A.*

---

1. Sugar Supply of the United States: Its Extent and Distribution on Aug. 31, 1917, Circular 96, U. S. Dept. Agriculture, Office of the Secretary, Washington, Jan. 31, 1918.

2. Sherman, H. C.: Food Products, New York, 1914, p. 440.

3. Abel, Mary Hinman: Sugar as Food, Farmers' Bull. 535, U. S. Dept. Agriculture.

### "CHILDREN FIRST."

"The results of underfeeding or indiscriminate food substitution in childhood are startlingly shown abroad as a result of the war, and are beginning to be evident in our own great cities." And "milk has no substitute in the diet of the child." These and other unqualified statements of the importance of guarding the milk supply to prevent the physical deterioration of American children during the war are scattered through the latest report issued by the Children's Bureau of the U. S. Department of Labor and entitled "Milk, the Indispensable Food for Children."

This report, with its striking figures showing a decrease in the amount of milk now available and in the amount which is finding its way to the children in poor homes, has special interest in connection with the campaign to save 100,000 lives of babies and little children during the second year of the war. It not only emphasizes the fact that children who are deprived of milk can not thrive properly, but it analyzes the changes in the production and export of dairy products during the war and shows the necessity of public action.

"The nourishment of our children is the first duty of the Nation. Since milk and milk products are a vital necessity for children, for nursing mothers, and for the sick and wounded, the public should be made to realize that the children's need for dairy products should be assured."

England and Italy have regulated the sale of cream and curtailed the use of butter, in order that their child population might receive the more adequate and economical nourishment offered by whole milk. Germany, early in the war, provided that the adult civilian population might have milk only after the needs of children, mothers, invalids, and the army were met.

The report discusses the various forms in which cows' milk may be used for children. For the young baby, it says, there is nothing so good as mother's milk.

"Never before in the history of civilization has it been so urgent a matter that every child should have breast-milk for as long a time as possible, in order that every child that survives birth may have the best chance for life and health."

But for children under two other than those breast-fed, and for older children, the report states that cows' milk is an absolute necessity if disease and death are to be kept within bounds and if the coming generation is to survive and to sustain the national standards. "'Children first' should be part of the national food slogan."

"It is the duty now of every individual community to see that its children have milk of good quality and in sufficient amount to assure their normal development. To do this the price of milk must be controlled or fixed, and the milk supply to infants and children carefully safeguarded. The malnutrition of our children was, even before 1914, a serious national problem and one demanding urgent attention. Poverty and ignorance of dietary essentials have been ever-present factors in the malnutrition of the young, and war conditions can not fail to increase the gravity of the situation and the difficulties of maintaining the health of the Nation."

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### VOCATIONAL REEDUCATION.

That 100,000 out of every 1,000,000 soldiers sent overseas will return to the United States during the first year of fighting, and that 20,000 of these will need some kind of vocational reeducation or rehabilitation, is the estimate made by the Federal Board for Vocational Education in a report just published as Senate Document 166.

"Long before the close of activities in the summer of 1918, the return of men will begin, and vocational reeducation must start with the first men sent back, and must be developed as the number of men in hand for training increases," declares the report. "The development of facilities for undertaking vocational reeducation must, in fact,



anticipate the return of the men, since adequate provision can not be improvised after the men are actually in hand for training."

A comprehensive Federal system for the reeducation and placement in wage-earning occupations of every disabled soldier and sailor is presented by the Federal board. This plan involved a central administrative agency at Washington, the coordination with that agency or every Federal and State agency concerned and with similar public, semi-public and private agencies, the establishment of "curative workshops" for the treatment of war cripples, together with a complete system providing for subsistence and pay during the period of reeducation.

Basing its opinion on foreign experience, the report declares that "vocational rehabilitation can not be regarded as costing the community, except temporarily, anything whatever. The disability of the soldier or sailor is an economic handicap reducing productive power. Unless the men are vocationally reestablished, and to the extent that they are not completely reestablished, the economic loss to the community will be cumulative during a long period of years. Even a slight increase in vocational capacity, as a result of vocational training initiated during the period of convalescence, will result in an economic gain which, also, will be cumulative over a long period. This aggregate cumulative gain will certainly exceed any expenditures for vocational rehabilitation."

The increase of the earning power of the handicapped man, thus rendering him economically independent, is the ultimate object of this program.

The plea is made that "all the experience and all the special equipment required for emergency war work will be needed to provide for similar work in the vocational rehabilitation of men disabled in factories and workshops, of the victims of accident in all dangerous employments, and of the thousands of otherwise injured and crippled persons thrown upon the community each year. The number of such persons in normal

times greatly exceeds the capacity thus far developed for their vocational rehabilitation."

In addition to the above it discusses methods of financing, organizing, and administering a national system of vocational rehabilitation; foreign experience and legislation are reviewed; and the proceedings of an inter-departmental conference held on the subject in Washington are summarized together with suggested legislation.

### THE CHICAGO SESSION.

#### *Section of Miscellaneous Topics to Consider Reeducation and Rehabilitation of Disabled Soldiers.*

At its recent meeting the Council on Scientific Assembly arranged for meetings of the Section on Miscellaneous Topics, the subject to be taken up being the reeducation and rehabilitation of the disabled soldiers. Major Frank Billings, head of this division in the Surgeon-General's Office, has accepted the chairmanship of the section. The subject is one of great importance, especially to medical men. Further announcement will be made later.

#### *Special General Meeting.*

In addition to the patriotic meeting which will be held on Thursday evening, June 13, and which will be addressed by men prominent in public affairs, there will also be a general meeting on Wednesday evening, June 12, at which eminent physicians who have been active in the medical military service of our nation and its allies will take part.

#### *Section Meeting Places.*

The tentative arrangements for places of meeting are as follows:

Section on Practice of Medicine.—Banquet Room, Hotel Morrison.

Section on Ophthalmology and on Laryngology, Otology and Rhinology.—Grand Ball Room and Red Room, respectively, Hotel La Salle.

Sections on Nervous and Mental Diseases and on Dermatology. — Ball Room and English Room, respectively, Blackstone Hotel.

The remaining Sections will be grouped, meeting in the Auditorium Theatre, the Auditorium Hotel and the Congress Hotel. The theatre will house in its main auditorium, the Section on Surgery, General and Abdominal, and in two smaller halls, the Sections on Genito-Urinary Diseases and on Gastro-Enterology and Proctology.

In the Auditorium Hotel, the Ball Room will be the meeting place of the Section on Pathology and Physiology, the Ladies' Parlor the meeting place of the Section of Pharmacology and Therapeutics, and the Section on Preventive Medicine and Public Health will meet in the banquet hall.

In the Congress Hotel, the Elizabethan

Room will be the meeting place of the Section on Orthopedic Surgery and the Gold Room, the Section on Obstetrics, Gynecology and Abdominal Surgery; the Florentine Room, the Section on Diseases of Children, and the Green Room, the Section on Stomatology.

The Hotel Sherman will be the general headquarters where will be housed the Registration Bureau, the Information Bureau, the American Medical Association Branch Postoffice, as well as the Scientific and Commercial Exhibits.

In next week's issue the accommodations offered by these and the other hotels of Chicago for those who attend the annual session will be announced.

## Cancer Department

*"In the early treatment of cancer lies the hope of cure"*

AMERICAN SOCIETY FOR THE CONTROL OF CANCER

### NEW FIELD OF INSTRUCTION.

The headquarters office has recently been in communication with the Department of Public Instruction of the Bureau of Commercial Economics, Washington, D. C., with regard to a plan for bringing the fundamental facts for the control of cancer to the attention of motion picture audiences throughout the country.

Mr. Francis Holey, the Director of the Bureau, assures us that if our organization will develop a picture of simple texts and a few illustrations, he will arrange for its circulation. He is confident that a very comprehensive lesson can thus be taught which will bring the public to a realization of the incidence of this disease and the necessity for its early eradication if the mortality from cancer is to be lowered.

### DR. BRISTOL TO HEAD WORK FOR THE CONTROL OF CANCER IN MAINE.

Dr. L. D. Bristol, who was Chairman of the North Dakota Committee of the Amer-

ican Society for the Control of Cancer in 1916, has since last July been Commissioner of the State Department of Health in Maine, which, organized along the same lines as those of the Massachusetts and New York State Departments, has now taken the place of the former State Board of Health.

Dr. Bristol having kept in close touch with the problem of the control of cancer since leaving North Dakota, where he was Director of State Public Health Laboratories, formulated a plan for the free diagnosis of tissue for malignancy in the Maine State Laboratory, which went into effect on the first of January, 1918. It is reported that already there has been considerable demand for such service.

The Society has now designated Dr. Bristol as Chairman of our State Committee in Maine and he has been authorized to appoint members of a committee to promote the work in that state.

It will be recalled that Dr. Bristol, as Chairman of a special committee of this Society appointed to make a survey of the

existing public facilities in the several states for the examination of specimens of suspected cancerous tissue, was the author of the Committee's report on "Free Tumor Diagnosis as a Function of State Public Health Laboratories." That report, prepared as the basis for consideration of the need for and the means of a general extension of facilities for the laboratory diagnosis of cancer under public auspices, was distributed as No. 11 in the series of bulletins published by our organization.

A number of copies of the Bulletin are still available and may be had by any of our readers interested in the subject, upon request to the headquarters office of the Society.

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#### MEMBERS OF THE CANCER SOCIETY'S LECTURE BUREAU TO BE CALLED UPON TO LECTURE TO CIVILIAN GROUPS ON "SOCIAL HYGIENE AND THE WAR."

In connection with the campaign to protect the Army by combating venereal diseases in civil communities, the Cancer Society has been asked by direction of Dr. Franklin Martin, Member of the Advisory Commission of the Council of National Defense and one of the Directors of our organization, to furnish a list of the medical men throughout the country who are on our Lecture Bureau and who from time to time present the work of the Society in addresses before lay and professional groups.

We are assured that our list of speakers will be very helpful as it is felt that the type of man who can speak well on this public health subject will be valuable in social hygiene work. Thanks for our cooperation in this matter have been extended by the Committee for Civilian Cooperation in Combating Venereal Diseases of the General Medical Board.

#### NEW AND NONOFFICIAL REMEDIES.

**DICHLORAMINE-T (Monsanto).**—A brand of dichloramine-T complying with the standards of New and Nonofficial Remedies. For a description of the actions, uses, dosage and chemical and physical properties see New and Nonofficial Remedies, 1918, p. 157. Monsanto Chemical Works, St. Louis, Mo. (*Jour. A. M. A.*, April 6, 1918, p. 999.)

**GILLILAND'S CONCENTRATED AND REFINED DIPHTHERIA ANTITOXIN.** — Marketed in syringes containing each 1,000, 3,000, 5,000, 7,500, 10,000, 15,000 and 20,000 units. Gilliland Laboratories, Ambler, Pa.

**GILLILAND'S CONCENTRATED AND REFINED TETANUS ANTITOXIN.**—Marketed in syringes containing each 1,500, 3,000 and 5,000 units. Gilliland Laboratories, Ambler, Pa. (*Jour. A. M. A.*, April 20, 1918, p. 1159.)

**NORMAL HORSE SERUM.** — Marketed in syringes each containing 10 c. c.; also in ampules containing from 10 to 100 c. c. as ordered. Gilliland Laboratories, Ambler, Pa.

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## Publisher's Notes

### ASCENDENCY OF THE AMPOULE.

As evidence of the favor with which the medical profession has come to regard the glaseptic ampoule, it is worthy of note that Parke, Davis & Co. now supply in this form more than eighty sterilized solutions for hypodermic use. The fact is significant when it is remembered that the "ready-to-use" solution is distinctly a modern institution, having its introduction in this country less than ten years ago.

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Parke, Davis & Co. publish an "Ampoules" brochure, a valuable little book of seventy pages, giving a list of their sterilized solutions, with therapeutic suggestions, dosage, descriptions of packages, prices, etc. The work contains a useful therapeutic index and an informing chapter on hypodermic medication in general. Physicians and surgeons are advised to send to the Detroit laboratories of Parke, Davis & Co. for a copy of the book, requests for which are invited.

### THE BULGARIAN BACILLUS AS A REMEDIAL AGENT.

A simple and effective remedy for the summer diarrheas and other common ailments of the intestinal canal is the Bulgarian bacillus. This was popularized a few years ago by the late Professor Metchnikoff, who pointed out that this organism, in the form of buttermilk, is extensively used by the Bulgarians, who have the reputation of being the longest-lived people in Europe. While this lactic acid organism is not, of course, a panacea for senility, it is a remedy of very great value for many intestinal affections. Clock and others have shown that by its use summer diarrheas of children can be controlled more quickly, and with less disturbance of the child's regular food than with any other remedy. It has also been recommended for intestinal indigestion, auto-toxemia of intestinal origin, and even for such serious diseases as diabetes.

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Forty-Sixth Annual Meeting at Miami, May, 1919

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## Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV  
No. 11

St. Augustine and Jacksonville, Fla., May, 1918

Yearly Subscription, \$1.50  
Single Copy, 15c.

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, May, 1918

Number 11

## ORIGINAL ARTICLES

### TREATMENT OF SYPHILIS OF THE CENTRAL NERVOUS SYSTEM.\*

H. MASON SMITH, M. D.,

Chattahoochee, Fla.

In presenting a paper on a subject about which so much literature has recently appeared, and on which I have nothing original to offer, I have in view two purposes: First, to show the efficiency of late methods of treatment in cases which were formerly considered as hopeless, and thereby stimulate an interest in the profession toward reclaiming the paretics and tabetics; and secondly, to emphasize the importance of an early diagnosis of luetic infections of the central nervous system so that treatment can be initiated before too much damage is done for repair.

Sometime after the spirochaetes were discovered in the brains of the victims of paresis and tabes, and these diseases were no longer considered as metasyphilitic or parasymphilitic, but as syphilis *per se*, a number of treatments were originated, all of which were antisymphilitic in their character and intensive in their course. In a way, all of these methods of treatment were futile even though they were antisymphilitic. This brought about considerable study, which revealed the fact to some experimenters that medical agents, whether given internally, intramuscularly or intravenously, did not find their way to the seat of the trouble in the brain or spinal cord, as there was apparently no connection between the blood circulation and the cerebrospinal fluid, and that no medicinal agents reached the cerebrospinal fluid from the blood in sufficient quantity to have any effect. It was further learned that the barrier be-

tween the blood circulation and the cerebrospinal fluid was the meninges, and especially the choroid plexus, which guard the openings to all the ventricles of the brain and to the spinal canal, and prevent the admission into it of medicinal agents or even antibodies, with the exception of hexamethylenamine and chloroform. This fact having been learned, the workers continued their search for a method of reaching the seat of the trouble, and in this way the intraspinal route of medication was found and opened up.

Numerous drugs and various medicinal agents were administered intraspinaly for the treatment of syphilis of the central nervous system, such as cyanide of mercury in salt solution and minimum doses of salvarsan. For one reason or another all of these treatments were unsatisfactory and in many instances very harmful to the patient.

Finally, Swift and Ellis, of the Rockefeller Institute, devised a treatment which is very efficacious and is in a way the standard treatment of all forms of this trouble. Much has recently been published on this subject and the Swift-Ellis treatment of syphilis of the central nervous system is fairly well known, but for the purpose of bringing out a few points I will reiterate briefly the salient features of their method.

Salvarsan is administered intravenously, weekly, in 0.6 or 0.9 gm. doses. Twenty minutes after each administration, at which time the salvarsan content of the blood is supposed to be at the highest point, 50 c. c. of blood is drawn off through a large caliber needle. This is placed on ice and kept over night and on the following morning when the clear serum is separated from the clot, diluted to a 40 per cent solution with normal saline, and after the spinal canal has been tapped

\*Read before the forty-fifth annual meeting of the Florida Medical Association, at Tampa, May 15-16, 1918.



and the fluid has been allowed to run until the flow has ceased and the fluid comes in drops, the solution of serum is allowed to run by gravity into the spinal canal, after which the patient is immediately put to bed with feet elevated so that the injected solution will gravitate to the cerebrum. By a series of experiments it has been learned that beyond a doubt this solution does reach the cortex of the brain. This treatment is repeated for four to ten weeks according to the reaction of the patient, and according to the changes in the globulin content and cell count in the spinal fluid.

With some modifications this method of treatment has been followed at the state hospital since it was made public by the authors in 1914. Other treatments, such as the injection of bichloride of mercury in serum, directly into the spinal canal, have been tried, but the results clinically and serologically have not been as good as the salvarsanized serum, as will be borne out by the laboratory records which we have on file at the hospital.

In 1916 I reported a series of four cases treated in this way, two of which were cerebrospinal syphilis and in young men, and two of paresis in men between forty and fifty years of age. With the exception of one of the paretics all of these cases were improved to such an extent that they went home and are there now. The one parietic who did not show improvement suffered a typical parietic decline and died about a year after the treatment was finished. The second case of paresis, who was allowed to go home in charge of his wife, has had no relapse and is now earning his living doing work of a simple nature. He has never been able to resume the position in the business world which he formerly occupied, but is doing carpenter work and chores of various kind, and socially is very happy. At the time of his admission to the hospital he displayed the classical symptoms of paresis physically, neurologically and mentally. He was in an exalted and confused mental state and entertained grandiose ideas regarding his own im-

portance. This exaltation and confusion advanced until he became so excited that he was placed on the ward where the most violent cases are kept. The cell count at this time was 20 per cmm.; Wassermann of both blood and spinal fluid was positive, and the globulin content was excessive. He was placed on specific treatment and did not show any improvement, but began to deteriorate physically, as is typical of paretics, until he became so demented and debilitated that he was placed on the nursery ward, where he required the same care as a baby.

The Swift-Ellis treatment was started on the first of March of that year. No improvement, however, was shown until the four treatments had been given, when he began to brighten up and notice things, and improvement continued until he left the hospital in the custody of his wife in the following November, at which time the pupillary and patella reflexes were about normal. There was no muscular incoordination or speech disturbances, and his serology showed a cell count of 5 per cmm., with no excessive globulin content. His wife reported his condition to us at frequent intervals for a long time after he was discharged, and the only mental abnormalities he has shown is childishness and a slight irritability.

In the other two young men the syphilis had not advanced to such a great extent as the spirochaetes had evidently not permeated to the parenchyma of the brain. In one there had been a stroke of paralysis which had cleared up, but left him confused and disoriented to some extent. He gave a negative Wassermann of blood and positive Wassermann of the spinal fluid, cell count 200 per cmm., and globulin in excess. After the Swift-Ellis treatment had been completed, his spinal fluid gave a negative Wassermann, the cell count was diminished to 15 per cmm., and the patient left the hospital about six months after admission. This case was doubtless one of cerebral syphilitic endarteritis with mild meningeal involvement, as shown by the high cell count, and would have become a case of paresis if allowed to advance.

In the other case the syphilitic infection of the brain was still in the cortex, and while the patient had been in the hospital for some six months previous to treatment, his recovery was uneventful after the Swift-Ellis treatment was administered, and he left the hospital with a negative serology. This patient has been returned to the hospital twice since that date, but each stay has been very short and the spinal fluid findings have been negative. He was merely in a state of depression mentally, which psychosis was not due to any pathology of syphilis.

The next case is one in whom the treatment was finished in March of last year, and which I merely report because of his arrested condition, which is remarkable from the fact that the patient was in such an advanced state of general paralysis that his intestinal tract and bladder were affected and he had suffered a complete loss of insight and judgment with no memory for present or past events, and was in a state of absolute confusion. There were altogether sixteen treatments of salvarsanized blood serum administered to him. When treatment was started with him his cell count was 144 per cmm.; Wassermann of blood and spinal fluid, four plus, and the globulin content was excessive. The serology gradually improved until now he gives a cell count of 10 per cmm., and no excessive globulin content but a mild Wassermann of the spinal fluid. Clinically, he has improved to the extent that he does not have any further incontinence of urine and feces and has gained 20 pounds. Mentally, he has shown some improvement, but in this we do not hope for much because the brain tissue which has been permanently damaged can not be replaced.

A new method of treatment, which is indeed very promising, has recently been advanced by J. Henry Barbat, of San Francisco, Cal., who has recently made a report on a number of cases treated by this method. While the principle of the treatment is the same as the Swift-Ellis—that is of getting directly into the cerebrospinal canal the salvarsan or arsenic—the method

is different and is based on the permeability of the meninges under certain conditions, and on the fact that the source of the cerebrospinal fluid is in the choroid plexus, and possibly the ependymal cells. He believes that the meninges are permeable to medicinal agents, or especially to salvarsan, if at the time the blood content of this substance is high, as after intravenous injection all of the spinal fluid is removed by tapping the spinal canal; that since there is no counter-pressure in the spinal canal, the blood serum permeates the meninges and carries the arsenic with it, or it deposits the arsenic in the meninges from which the spinal fluid is derived, and that the newly formed fluid is loaded with arsenic.

Working on this hypothesis he removes all of the spinal fluid twenty minutes after the intravenous injection of salvarsan. This spinal fluid is caught in two portions, the last of which is caught when the interval between drops begins to be lengthened. Arsenic is recovered in the last portion of this spinal fluid in about 25 per cent of the cases. Of twenty-six cases treated in this way he recovered arsenic in the spinal fluid obtained from 25 cases, twenty-four hours after injection. This method has also been followed out at the hospital in a number of cases since the report was made by Dr. Barbat in January. All of these cases have shown physical improvement and in some there has been an improvement serologically and mentally.

The treatment has not been under way long enough to have obtained any positive results, but I have selected for the purpose of this paper only two cases of advanced paresis out of a large number we have on file to show there has been a gradual improvement. In each case treatments were given at the same time and four treatments in all have been administered. In one on March 27th the cell count was 49 per cmm., and the globulin content excessive; the next treatment given April 3d the cell count was 46, globulin excessive; the next dose on April 17th, cell count 11, globulin reduced; May 1st, cell count 1 or normal, globulin reaction

negative. The other case received the first treatment on March 27th, cell count 136, globulin excessive; on April 3d, cell count 76, globulin reduced; April 17th, cell count 33, globulin still reduced; May 1st, cell count 5 or normal, globulin reaction negative. Both were cases of advanced paresis. The effect of the withdrawal of all of the spinal fluid has not at any time been marked, and the headache following is frequently not as bad as that which attends the withdrawal of only a small quantity of spinal fluid.

#### *Conclusion.*

In reviewing this work and summarizing the results, the following conclusions have been reached: That if cases of cerebrospinal syphilis can be received and treatment started before there has been tissue destroyed or any irreparable damage done to the brain, and while the infection is still in the meninges, and near the surface which is in reach of the spinal fluid, the prognosis with either of the treatments which I have outlined is fairly good. I selected one case for this paper of advanced paresis in which the disease had been checked and the patient improved physically; the mentality had gotten into an arrested state but not improved, as we can not hope to repair damage to brain tissue which has been affected by this degenerative disease.

In those cases where the infection has reached the parenchyma of the brain, and where the spirochætes are beyond the reach of the cerebrospinal fluid the prognosis is bad. In cases that have apparently recovered there may be at some point in the brain some syphilitic process which nature has in a compensatory effort walled off so that the contents are protected from the spinal fluid which contains arsenic and other medicinal agents, and at some time this wall may break down and set free into the brain a large number of spirochætes. For this reason it is advisable that patients who have once been affected with cerebrospinal syphilis have a Wassermann and cell count of the spinal fluid made at intervals of every six months,

and treatment should be repeated if the findings are positive.

The advanced cases, however, are worthy of a trial, and if the process is not too deeply hidden some improvement can at least be hoped for. At any rate for cases of this nature this is a most rational and the only treatment.

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### COLONY CARE FOR THE EPILEPTIC AND FEEBLE-MINDED OF FLORIDA.\*

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The epileptic and feeble-minded have much in common. Nearly all epileptics are feeble-minded, becoming more and more so as they grow older, the exception being the small percentage that, under proper surroundings and treatment, react in some way and have the seizures less often, less severe, or a cessation of them. Those whose mentality, properly tested, shows retardation of three years, or a difference of three years between their age and mental growth, under circumstances favorable to normal development, or grown persons having mentality equal to that of a normal child of ten years, are termed feeble-minded. In the matter of care and treatment they may consistently be considered together.

Believing that the welfare of this class of patients already has the attention of every progressive medical man, and actuated by a desire to stimulate a fuller consideration of modern methods of handling such defectives in our state, I present this paper instead of one more strictly medical.

Careful study of the epileptic and feeble-minded shows that in common they (1) lack self-control, and for this reason yield easily to temptation; (2) usually fail to earn an independent living and drift easily into immorality and crime; (3) often become objects of charity and state wards; (4) transmit their defects from parent to child; (5)

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\*Read by title before the forty-fifth annual meeting of the Florida Medical Association, at Tampa, May 15-16, 1918.



have an unusually high birth rate among them in the absence of proper moral guidance, complicating every social problem; (6) seldom if ever become normal; (7) require individual training in which hand—not head—work must be emphasized; (8) both need proper institutional care.

Since the right method of caring for them eventually costs less than neglect, and at the same time assures to them the privilege of living happier lives, many of them useful lives, the well-being of these unfortunate ones becomes a medical problem, meriting our careful consideration.

Taking the lowest figures mentioned there are two epileptics and three feeble-minded persons to each thousand. This would give Florida a little less than 5,000 such defectives. Of these fully 1,000 are women of child-bearing age. At least 1,200 are indigent and supported by city, county or state.

More than half of the states in the union have made appropriate provisions for the indigent epileptic population within their borders, and only sixteen remain that have not provided the necessary facilities to care for and train their feeble-minded. Florida does not have the distinction of being on the honor roll in either count, only to the extent that if either of these two classes show distinct tendencies to crime, they are convicted of crime, or are committed as insane; they have such custodial care as our state is able to give at the institutions at Ocala, Marianna and Chattahoochee.

On May 1, 1918, there were at the Florida Hospital for the Insane 148 epileptics and 163 feeble-minded patients (not including idiots). They are getting the best treatment that the crowded conditions will permit, but why should they be kept there when they can be cared for at less expense in an institution especially suited to their needs? Should they not have the same consideration, chance and opportunity for training as our deaf, dumb and blind? It is evident that those of our state who are interested in these patients are beginning to ask such questions and plan

for improvement for them. In 1915 a commission was created by the Legislature of Florida to investigate the need of an institution for the indigent epileptic and feeble-minded. So much information was obtained as a result of the investigation inaugurated by the commission, that a partial report was made in 1917 and the Legislature of that year continued the work and membership of the commission that it might complete the important duty assigned and report in full in 1919. The Women's Clubs are asking for facts and figures regarding this subject, representative citizens and business men are no longer considering the proposition a visionary scheme but a modern necessity.

The state officials, composing the Board of Commissioners of State Institutions, stand ready to do their part to relieve this situation, but must wait for the sanction of the Legislature as the legislative body makes the appropriations. The Legislature will make the necessary provisions when a sufficiently large number of the citizens of Florida interest themselves enough to impress upon the individual member the benefits of this system both to these patients and to the state at large.

One great writer and student of the subject of epilepsy has stated: <sup>1</sup> "Strangely enough, the same agents which are so beneficial in combating tuberculosis are of the greatest benefit in these cases. Work in the fresh air and good, wholesome, and carefully chosen food are better than medicine. Colonies with their large farms provide this to advantage and are thoroughly proven to be the most satisfactory method of treating and caring for this disease"; and the one society of the United States doing most to stimulate public interest in behalf of the feeble-minded says in one of several bulletins: <sup>2</sup> "Any plan for the care of such a large number of people must first be reasonably economical. It must be effective. It must prove satisfactory to parents and

<sup>1</sup> William C. Graves, *Public and Private Care of Epileptics in the United States and Canada*, December 31, 1914.

<sup>2</sup> Bulletin No. 2, Committee on Provision for the Feeble-minded, 1917.

guardians as well as to the public generally. It must be capable of early application. \* \* In the hospitals for the insane, the feeble-minded and epileptics are adding to the already overcrowded condition. They do not need the care of the expert physician and the expensive protected buildings — they want mothering, directing and the opportunity of the land. They need a job, with material found with which to work, instruction as to what to do, a place to perform labor, someone to take care of the product, and encouragement—and they are useful and happy.”

In considering a colony plan the first item should be plenty of the right kind of land. There should not be less than 300 acres for 500 patients, and an acre for each person has been designated by some as the minimum. Great care in the selection of a location is vital. The tract selected for the most part should be woodland. It should be high, well-drained, healthy and well-watered by springs or stream, with several grades and varieties of soil, some for general farming, some for trucking, and some for pasture. The colony should be located not far from some important town so that supplies may be received and produce shipped without delay, and relatives may visit conveniently. The middle peninsular portion of the state seems preferable as a location on account of the advantages of the climate and the low cost of keeping the colonists warm in the winter.

After the location for the buildings has been selected, the boys who are to form the nucleus of the colony, and are able to work, should go into camp, properly supervised, and clear up and get in readiness the grounds before the carpenters come to build. When everything is in readiness to begin building, the boys can begin clearing the farm. The work of helping make a new home will be fun for them.

Plenty of ground should be set apart for the proper development of the colony to prevent crowding in the future, it matters not how the numbers increase. In the laying out of the ground no natural advantage of the location should be overlooked that would

make it a beautiful, healthful, happy place to live.

The cottages to be used as homes for the patients may be frame or cement-block bungalows. They should be one-story, screened, well lighted, and modern in every particular. Each cottage should accommodate thirty-five to fifty, a feature of each being sheds or porches that will permit sleeping out in the open. Groups of buildings as homes for each race and sex should form units of the colony and be sufficiently widely separated to give the greatest freedom and prevent crowding as the colony grows. Correct arrangement of these four groups should have them not too far from the hospital, administrative office, chapel, and amusement hall; such buildings to occupy a position as nearly central as possible and equally accessible to all. Instead of four hospitals there should be one hospital with wards for the care of each race and sex. The buildings already mentioned, plus wide streets and shady parks, will make a good beginning for the colony.

Then in their rightful places should be located the dairy, the barns, the piggery, light, power and water plants, storage houses, shop and other industrial buildings, the store, kindergarten and colony playground.

The officers' cottages and employees' dormitories should occupy positions as near the entrance to the grounds and as far from the patients' homes as is possible so that their resting hours may be in every way a change from the scene of the arduous hours on duty.

The farm and garden, gradually developed, will become the life and backbone of the colony, furnishing at the same time proper use of nature's wonderful tonics, sunshine, exercise and pure fresh air, that mean so much to these unfortunate sons and daughters of Florida.

The foregoing are only a few of the many points equally applicable and important in making plans for the colony, the details of which may be more fully worked out when such provisions become an actuality.

The need and advantages of such a plan for handling the classes mentioned above may be summarized as follows: It would (a) lessen the cost of maintenance, on account of less expensive buildings and a reduction in the nursing force; (b) provide facilities for training the patients to do many things with their hands that are not only a genuine pleasure to them but profitable. A vast deal of work toward maintaining a colony can be done by the patients; (c) create a home atmosphere for those whose malady denies to them the blessings of real home life, and eliminate the embarrassment that constantly complicates the situation on the outside; (d) remove this class of patients from the hospital for the insane to form the beginning of the colony and relieve the crowded conditions, possibly avoiding the necessity of the proposed additional institution for the insane for many years; (e) serve to train and make useful a large number of Florida's children not in any institution and for whom no educational provision has been made; (f) give opportunity for many, now objects of charity, to at least become partially self-sustaining; (g) provide the proper moral guidance and protection to prevent such as have immoral tendencies from drifting into crime and shame; (h) prevent and check epilepsy and feeble-mindedness in future generations by preventing parenthood so far as they are concerned, and thus cut off at its source at least three-fourths of the suffering and expense chargeable to these disorders in our state.

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#### RELATION OF THE MEDICAL PROFESSION TO EACH OTHER AND TO THE PUBLIC.\*

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Medical science is today in the greatest transitional period the world has ever known. Change, progress and new developments de-

mand prompt attention. The advances in the lifetime of some of the members of the profession now living have been greater than in all the history of the world before. The medical profession of today is facing world problems the like of which was never known. Medicine is no longer provincial but world-wide in its domain and relations, and if the profession fails to conceive and recognize this extended field of duty and usefulness it will fail to live up to past traditions.

The advances in hygiene, sanitation, preventive medicine and war surgery in the present conflict is almost beyond conception, and when the conflict is over the future will call for constructive, united, cooperative work. The day is fast passing when a physician can stand alone and not recognize his duty to his fellow practitioner and to humanity. Those that enter the war will come home with broader conceptions and better qualified for life's duties and professional work.

Never in the history of the world has there been a better, purer, nobler soldiery developed than the American soldier of today, and if the same principles had been applied in the development of the American citizen from infancy up to the age of 21 we would have the strongest nation on the face of the globe today. Never before has the moral element been so emphasized in the physical development and fitness of a soldier as in the American soldier at the present time. The public and the medical profession are now just beginning to recognize the basic principles of moral science in the physical development of the human race and a high-class efficient soldiery.

In the past a blind fanaticism and a supposed principle of liberty — "to do as one pleased" — has beclouded the vision, destroyed physical fitness, degenerated the race, added untold and incalculable physical and financial burdens on the American citizen, lessening our fitness for the present crisis. The war has given the American nation a shock and awakened the American

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\*Read before the forty-fifth annual meeting of the Florida Medical Association, at Tampa, May 15-16, 1918.



citizen and American physician as never before.

Never in the history of any nation has there been such moral leaders as are directing and leading the war forces of America today. Must I say the medical profession is having an object lesson forced upon them by the action of the military authorities in preventing venereal diseases and preventing the drinking of alcoholic beverages by the soldiers, thereby materially lessening crime, vice and disease. It has taken man centuries to overcome prejudice and even begin to recognize the effect of moral science in the physical development and fitness of the human race. That great monster, so-called "human liberty," has killed its millions and it has taken a diabolical reign of German "Kultur" to awaken the American people to a truer conception of human liberty. America has the opportunity today to lead the world in demonstrating the true principles of human liberty.

The President has sounded the keynote of national liberty and purity, the army and navy have established high standards of moral purity and fitness for duty. Now will the American citizen and the medical profession do their duty and sanction, sustain and support that which leads to a true liberty, which will uplift, upbuild and improve the race of mankind the world over? We have been groveling in the mire and filth of supposed liberty long enough to wake up to the fact that *absolute liberty demands absolute purity*.

We abhor and detest "German Kultur," while in the past we embraced so-called human liberty, in the form of venereal diseases, alcoholic beverages, and immoral practices and allowed it to fasten its fangs in the lives of innocent children, destroy young manhood and womanhood, weaken the American citizen, lessen the vitality of the American soldier and render us less efficient as a nation in our power to destroy "German Kultur." Yet we have with us American citizens who now advocate the further manufacture and sale of alcoholic beverages to

further weaken us as citizens, weaken and destroy the efficiency of our soldiers. What could be more pro-German? If this war can destroy both, "German Kultur" and so-called "human liberty," making the world indeed and in truth free, then the war will not have been in vain.

The medical profession has disintegrating factors within its own ranks that must be corrected if we retain the respect, confidence and cooperation of the public, without which medicine of the future can not advance as the times demand. The incompetent must become competent or take a back seat. The state must take advance steps in medical legislation, and the State Medical Association should be the main factor in shaping that legislation. Legislation is needed to eliminate the unfit in the profession, also to secure efficiency in sanitation and preventive medicine. We should eliminate the unscrupulous practitioner from our midst, foster and sustain cooperative work. In this day no one can be efficient in all lines of work, one must depend on others for cooperative diagnosis for efficient work, which means closer professional relations and greater confidence in each other. This will call for a high morale of the medical profession, honest, square, upright dealing with each other, patients and the public not only in private practice but in civic, community, state and national work. We can not secure such cooperation and support by petty jealousies, contention and strife in our ranks, by commercializing the profession, by bartering and trafficking our patients at so much per head or on commission when we are dealing with suffering humanity at a time that should demand that which is highest, noblest and best in the profession. Human life is too sacred, the honor of the profession among true men too high to condone or endorse such actions. He who takes or gives commissions for or to secure his patients lowers himself in his own estimation, else he would turn on the light and inform the public or his patrons of his actions. The fee-splitter and commission-giver are parasites sapping and destroying confidence

in the medical profession. Such men never have been and never will be leaders in the medical profession or in scientific discoveries. They are not admitted to the American College of Surgeons nor to the *clinics* of the American Clinical Congress of Surgeons. In some states such actions are a criminal offense.

The fees for surgical work should be well considered and equitably adjusted so as to render justice to all and harm no one vitally interested. The surgical fee should be reasonable and in proportion to responsibility, character and competency of services rendered. Large fees for incompetent work or where people are not able to pay are a reproach to the profession. Large fees paid to the surgeon for operative work when the patient is not able to pay the family physician for honest service faithfully rendered is unjust and not in keeping with the higher principles of the medical profession. There is a golden rule to guide the honorable physician or surgeon in dealing with his patients: "Treat every patient as you would like to be treated if in their place, charge every patient what you would be willing to pay if in their place or circumstances."

Professional expert testimony has done much to lower the confidence of the public in the medical profession. It will ever be so, as long as the present legal methods of handling such cases continue. The state should have statutes governing expert testimony, especially in cases of insanity or mental degeneracy in which the Superintendent of the State Insane Asylum and a competent physician selected by each, the prosecution and defense, shall constitute a tribunal to decide the mental responsibility of the person in question. An examination by such a tribunal would be much more likely to secure justice for both the accused and the state and far more creditable to the legal and medical profession.

Medicine in its evolution has had much to contend with; in primitive times it was primitive in character, passing through many stages from incantations, mysticism and

ignorance into the light of knowledge and scientific investigation, so that to day it is one of the most learned professions on the face of the globe.

One can not read "Medical Research and Human Welfare," by W. W. Keen, M. D., F. A. C. S., giving a record of personal experience of professional life of fifty-seven years, without being impressed with the wonderful medical age in which we live, the immense value of medical research to human welfare and the debt of gratitude the general public owe the real workers in the medical profession.

In evidence of this statement let us take a brief survey of some of the recent discoveries in medicine: Keen classes bacteriology as the most important discovery ever made in pathology and probably the most important discovery ever made in any department of medicine. The foundation for this work was laid by Pasteur, Lister and Koch, and principally within the last thirty years. "Pasteur and Lister exploded the theory of spontaneous generation and established the germ theory of putrefaction. \* \* Their work laid the foundation for the establishment of principles of asepsis, antisepsis and disinfection in modern surgery and obstetrics, also the basic principles that govern the development, control and prevention of many infectious and contagious diseases." In days gone-by puerperal fever has been known to slay as many as 50 per cent of mothers in some hospitals. The death rate was so high, they had to be closed, and some physicians had to give up their obstetrical practice for a time, their death rate was so high.

"In 1879 (Keen's M. R., p. 44), less than forty years ago, this subject was being discussed at the Paris Academy of Medicine and all were ignorant of the cause. Pasteur suddenly interrupted an eloquent speaker and stated it was of bacterial origin and carried by the doctors and nurses. His colleague retorted he was afraid this strange microbe would never be found. Pasteur at once stepped to the blackboard and drawing what we know to be the streptococcus, said

there it is and there it was. What was the result? Now puerperal fever slays only 1 in 300 to as low as 1 in 1,250.

Keen continued: "Verily, Pasteur was one of God's best gifts to humanity. Every wife and every husband should know these facts and treasure Pasteur's memory in their hearts."

Contrast surgery during the Civil War with the present World War. We are told (p. 55) "that from wounds, especially gunshot wounds, the death rate was fearful. Blood-poisoning frequent and the death rate 97.4 per cent; lockjaw frequent and death rate 89 per cent; in ordinary operations the death rate ranged from 15 to 25 and 50 per cent or more. To open the head, the chest, or the abdomen was then almost equivalent to a death warrant."

In this day abdominal operations are comparatively safe in competent hands; in interval operations for appendicitis the death rate should not be over 1 in 200, 300 or 400 operations; the brain, lungs, and even the heart are fruitful fields for surgery.

Crile, speaking at the last Clinical Congress of Surgeons in regard to the British Medical Service, states: "They kept their vast army, that vast army that lives like amphibians in the chill waters and mud of Flanders, more free from colds, from pneumonia, from typhoid, than our civilian population of Chicago. Through perfection of organization, through research and surgical experience, through the invention of new instruments and apparatus, of new methods and new technique, the death rate from wounds, operations and infections in the British and French lines is reduced to an incredible minimum."

Major Charles H. Mayo, at the same Clinical Congress, stated: "Only through medicine has it been possible, with the enormous number of men in the field, to carry on the war for three years. Had it not been for medical efficiency the war would have been terminated long ago, from the same causes that have terminated wars in the past—through disease and infection. We

would possibly have had brought on us a very unsatisfactory peace, which would be worse than no peace at all. Through medical efficiency the war will be carried on to a final termination which will end the wars of the present age, and democracy will be safe in the world. We are proud to say we are returning in excess of 80 per cent injured back to the front."

Sir Berkeley Moynihan, Colonel British Army Medical Corps, at the same congress stated: "History of medicine in the tropics is the history of the military medical service of America and Great Britain. The hands of all men build the Temple of Science, but now and then, once, perhaps twice, in a generation we have the high privilege of having among our number one of the great architects of the Temple of Science. You are perhaps as full of joy as I am, to think at this moment and on this platform are two of the men, both of them Americans, who have designed some of the magnificent additions which are being made to that glorious Temple of Science in Medicine and in Surgery. I need not tell you I refer to General Gorgas and Major Mayo."

Dr. D. J. Davis (November *Scientific Monthly*, p. 399) writes: "We speak of this war resulting in the loss and maiming of millions. Bubonic plague, the black death, five centuries ago in one epidemic in Europe killed 25,000,000 persons. One might point to the army of 150,000 in the United States alone carried off each year by the tubercle bacillus, another 150,000 destroyed by the pneumococcus, 25,000 by the typhoid bacillus, several thousand more by smallpox, and so on. What a pity some of the energy, time and money spent on the great war could not be spent in combatting the deadly microbe. A combined attack against several of our great diseases, such as the nations are making against each other, would no doubt result in their extinction."

In the fight against yellow fever we are told "Dr. Agramonte nearly lost his life, that Dr. Lazear and Miss Maas, a nurse, and others fell as victims in experimental work.



As a reward to the world from their sacrifices yellow fever has been banished from our shore, also from Cuba, and by the scientific work following, the Panama Canal Zone has been made practically a health resort."

Keen tells us that Goldberg of America and Nicolle of Algiers discovered that the body louse was the cause of typhus fever. Continuing, he states: "Among Americans who have confirmed this discovery, I wish to mention with special honor two of our fellow countrymen, Drs. Conniff and Ricketts. Both at the threshold of promising careers, they fell at their posts, and have added two more names to the martyr-roll of science. They fully understood their danger but cheerfully made the sacrifice."

Listen to what Pasteur did for humanity (p. 52): "He discovered the real cause of fermentation, then of putrefaction. He laid the ghost of spontaneous generation. He built the foundation of bacteriology. He proved the germ theory of disease. He saved for his beloved France the several industries of beer, of wine, of vinegar, of silk, of cattle, of poultry, of swine. Better than all these he showed how to abolish child-bed fever and hydrophobia among his fellow men. Fifteen victories and not one Waterloo!"

Bubonic plague in the past has killed its victims by the thousands or by the million, but thanks to medical research such destruction of human life is a thing of the past. It has been proven (M. R., p. 70) that the rat flea carries the infection from rat to man. "In the outbreak of bubonic plague in San Francisco, Surgeon-General Rupert Blue looked after the patients, trapped and poisoned every rat and rat-proofed all their possible places of refuge. For eight years or more there has not been a case of plague in San Francisco.

"In the outbreak in New Orleans, 1915, nearly five hundred thousand rats were caught; two hundred and sixty-five infected rats were found in nearly three hundred thousand buildings which were examined, and the epidemic was arrested."

We have here two object lessons of value. The states were failing to cope adequately with the situation and the Government took charge and a blind man could recognize the result. When the United States declared war, what about the individual states' readiness and preparation for war—how efficient were the state militia? What lessons are we now learning in Government control in order to secure efficiency? The states must be subordinate to the Government in war questions and for efficiency must also be in health questions, and I might say the prohibition question is also a national question if we secure efficiency of the human race.

Diphtheria has slain children by the thousand in the past, but medical science with the aid of animal experimentation has developed antitoxine with the following results: "The death rate per 100,000 population has been reduced in Siberia from 411.9 to 40.1; Prussia, 143.1 to 22.6; Denmark, 134.0 to 7.9; Austria, 119.3 to 25.9; United States, 120.1 to 27.1."

Typhoid fever gives the following record (Keen, M. R., p. 103): "In the Civil War, 79,462 cases, 29,336 deaths; Boer War, 58,000 cases, 8,000 death; Spanish-American War, 20,738 cases, 1,580 deaths—86 per cent of the entire deaths in that entire war was due to typhoid fever.

"If the same ratio had prevailed in the present war there would have been 1,000,000 cases in the British army alone.

"In the early part of the war a few cases occurred for want of material for typhoid vaccination, but now it is stated: "Typhoid fever in war has practically disappeared."

This is only an index of what might be accomplished if the general public would only use the means at their command.

Smallpox gives another lesson recently (M. R., p. 64): "Between 1905 and 1915 Dr. V. G. Heiser, health officer in the Philippines, vaccinated over 8,000,000 without a single death. In India, during 1914 and 1915, 9,462,901 were vaccinated without a death, even with unsanitary conditions. Dr. Heiser vaccinated 1,000,000 in and around

Manila; before vaccination there was yearly about 6,000 deaths from smallpox, the year after vaccination not a single death. Dr. Heiser also reports: 'On a small isolated island of 2,000 population an old woman inoculated several cases with pus from a case of smallpox, resulting in 1,000 cases of smallpox with 400 deaths. Immediately after 800 were vaccinated, 400 escaping to the mountains; of the 800 there were no cases of smallpox and no deaths.'

"In 1885 a Pullman porter reached Montreal with smallpox, causing an epidemic with 3,164 deaths, and disfigured and blinded 10,000 or 20,000 more, besides the financial loss to the city, and all this from the acts of one person."

In an active practice of forty years I have never seen or known of a case of death or amputation from vaccination against smallpox, yet with the above facts and many more that might be secured, we have antivaccination fanatics and cranks parrotlike condemning vaccination. To scientific medicine they simply display their arrogance and ignorance and are a menace to any community. I have seen a genuine case of smallpox cure such cranks.

We have another set of cranks with us equally as arrogant and ignorant, the antivivisectionists. They are feather-weight mentally, not competent to do research work themselves, but with their ego mania try to obstruct research workers devoting their lifetime to research and human welfare, often risking their lives and some even sacrificing their lives for the good of humanity.

There is a brighter and better day coming for scientific medicine. Crile tells us in "Man — An Adaptive Mechanism," "That medicine is well through the second stage and has entered the final stage of synthesis in which practical working principles are being formulated, is evidenced especially by the increasing control of infectious diseases. In many instances the older volumes filled with dissertations on certain diseases contained less useful information than is now comprised in single sentences or words which

indicate both origin and control. With malaria and yellow fever explained by one word, mosquito; diphtheria reduced to bacillus and antitoxine; smallpox disposed of in vaccination; bubonic plague apprehended in infected vermin, and synthetic chemistry producing such a specific as salvarsan, there is hope for a like conquest of the host of chronic diseases, and a fairer promise of a future for preventive medicine."

What we need is more confidence in scientific medicine on the part of the general public and less resort to patent medicines, quack remedies and humbugs. A profession that has done so much for humanity by scientific research in laboratory investigations, animal experimentation and synthetic chemistry, resulting in the saving of thousands upon thousands of lives of men, women and children in the prevention and treatment of diphtheria, yellow fever, cholera, typhus fever, typhoid fever, hydrophobia, bubonic plague, syphilis, smallpox, malaria, tuberculosis, hookworm, tetanus, etc., and to these add the achievements of aseptic and antiseptic surgery in war and in peace; the antiseptic midwifery, saving the lives of wives and mothers and making many homes happy, and if this is not enough, count up the value of human lives saved in dollars and cents, and include it; even more, if you like, count up the millions upon millions of dollars saved in the prevention of diseases of animals, and what more could one want to inspire confidence in medical science?

For efficiency the profession will have to better qualify and fit themselves for cooperative work, health work and preventive medicine, and the public must see that properly qualified physicians are selected as health officers and paid an adequate salary for services rendered. Health work is civic business which means life and health or disease and death. For efficiency and health the health officer should be selected because of his fitness and qualifications and not as a political convenience; then he should have the proper cooperation of the city officials and citizens.

In conclusion, I wish to urge the profession to higher ideals in medicine. Ethics is said to be the "basic principles of right action." Then is any one willing to say he is not actuated by principles of right action in his relation to the profession and the public?

What we need is higher ethical relations and greater confidence in each other. Then the public will have greater confidence in the medical profession.

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### THE UVULA.\*

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The pharyngeal uvula is not a large organ, either in size or importance. The importance of its function probably does not compare with that of the cerebellar uvula; howbeit, the cerebellar functions are not clearly defined.

Its function is discussed by Lennox Browne, to whom frequent reference will be made, as follows: "The utility of the uvula has been the subject of much speculation. It is without doubt of great service, together with the rest of the palate and the epiglottis, in cutting off the oral cavity from the true respiratory channel in normal breathing. Probably it also acts as a drip stone, conducting the nasal secretions to the glosso-epiglottic *forsæ*, whence they are directed by the epiglottis into the pyriform *forsæ*, as pointed out first by Dobell. When relaxed abnormally, the nares are imperfectly closed in the acts of both swallowing and tone production, and there is a general paresis of the palatal muscles." Browne devotes more space to the uvula than all the other authorities at my command. Gray dismisses its anatomy with a few lines, as do other works, and as will be done here. Its histology is essentially similar to the rest of the soft palate. Its anatomy consists of the azygos uvulæ, a muscle composed of two cylindrical bundles in the median line of the soft palate,

each arising from the posterior nasal spine of the palate bone.

Among late authors its pathology is briefly considered. Elongation of the uvula is discussed by Price-Browne, Knight and Bryant, and Moore. Uvulitis, by them and by Shurly. Edema by Price-Browne. Moore takes up tumors. Lennox Browne discusses uvular symptomatology, pathology and treatment at such length and in such detail that circumstantial reference to his work is inadvisable. A brief reference is necessary to illustrate the conception of the uvula some forty years ago. Browne states that diseases of the uvula are 5 per cent of all throat diseases, and nearly 7 per cent of affections of the fauces and pharynx. His presentation of symptoms is a formidable indictment. I quote: "These vary greatly in different cases, and often require the nicest judgment for their discrimination. Thus, while one patient with an evidently very pendulous uvula will not complain of any inconvenience and then with apparently but slight local cause will exhibit well-marked symptoms. The usual sensation is that of a desire to frequently clear the throat of a source of irritation, this desire being only experienced at particular periods; as, for instance, on rising in the morning, on coming into a warm out of a cold atmosphere, and also when the general system is fatigued or disturbed. In more severe cases, there will, under similar circumstances, be hacking, irritable cough, with expectoration of small muco-gelatinous pellets, paroxysmal and spasmodic attacks, retching and vomiting. I have seen several cases in which the last-named symptom occurred on the patient taking the ordinary cold morning bath, and in one instance the breakfast had been daily rejected for many weeks. In more than one case, gargling after cleansing of the teeth had been followed by violent spasm, with bloody expectoration, clearly traced to come from the pharynx. When the uvula is very relaxed the greatest discomfort is felt as the patient lies down at night; many cases occur of spasm of the glottis—due to reflex irritation from this cause—so severe as to awake

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\*Read before the fifty-fifth annual meeting of the Florida Medical Association, at Tampa, May 15-16, 1918.



patients from sleep." "It is but natural that symptoms such as those described combine to bring the patient to a state of great nervous prostration; the want of sleep, the cough and the retching will produce great weakness and even emaciation, and the patient will appear to be suffering from phthisis or other grave organic disease; especially will this be suspected in those occasional cases in which there is an account given of fixed pain at some point in the chest, which on examination is found to be only another effect of reflex irritation." "Case 23—I was consulted in the year 1873 by a medical practitioner who complained of constant pain in the left subscapular region, with irritable cough, loss of flesh, and impairment of general health. On the recommendation of two physicians, eminent in chest diseases, he sold his practice, but he entirely recovered after the removal of his uvula. He is still well, and but recently retired from active professional work on account of advanced age." Case 24 is similar. "Gastric derangements will be aggravated by the presence of an elongated uvula, while on the other hand the symptoms caused by the relaxed palate will be increased by anything likely to induce or increase disorders of digestion."

The discussion goes on to much greater length, and he then takes up the treatment. He uses astringents and removal, stating "it is better to take off too much than too little," regretting that "it is unfortunate that this operation should encounter ill-founded opposition," and "that anything should be done to bring disrepute upon so valuable an operation, of which it has been truly written that "while hardly any slight affection of the throat produces such serious symptoms as elongation of the uvula, it is equally true that there is no slight operation that gives such complete and permanent relief as removal of the elongated extremity." The after-treatment is impressive, including styptics; cocain, applied to relieve pain, sometimes lasting a week; applications to the ear for reflex pain, and finally caution that the symptoms may persist for some time. The

caution would seem to be timely. The after-treatment seems a trifle ponderous to apply to so "slight an operation." Bifid uvula, the common malformation, is discussed, and tumors, including fibromata, adenomata, papillomata, cysts, angiomatica, and one epithelioma are recorded. Tumors are usually secondary to a primary condition elsewhere in the soft palate. Finally, the uvula was removed in diphtheria.

A case of uvulotomy lately seen and the memory of another seen some years ago interested me in the subject. I took up the matter with some hesitation, fearing that I would have to rely on my limited experience. Such proved to be the fact, until I discovered Lennox Browne. The subject is briefly dealt with in current literature, but even there uvulotomy is casually advised. In Browne I unearthed a mine of information, such as it is, of the nightmare variety. It is difficult to conceive how such absurdities originated. It is an instance of how a really good man can err. His work on anatomy, physiology and pathology is instructive, even now.

My experience with uvulotomy is limited. I may have done it a few times in general work. Since doing special work I have not done it. In my throat work, however, I have seen many uvulas, and have often been asked to operate. The usual complaint is that the palate is down, calling to mind the remedy of tying up a tuft of hair. With regard to the position of the palate and uvula, it should be borne in mind that their normal position, in nasal respiration, is in contact with the upper and posterior surfaces of the tongue, and in that sense, being down is just where they belong. I once heard an instructor, in answer to a complaint that the palate was down, remark that usually meant a syphilitic ulcer.

I have seen diseased uvulas, but it has always been when associated with a pathology of the soft palate and pharynx, especially of the lingual tonsil, the treatment for which relieved the uvula. Such a thing as a

selective pathology of the uvula has not come under my observation.

The function of the uvula seems to be an open question, mentioned above. My solution is to irritate the soft palate, and watch the uvula. During contraction of the soft palate the uvula partly, sometimes entirely, disappears. To me that indicates that, whatever other functions it may have, functionally as well as anatomically, it is an integral part of the soft palate. Assuming this, it is then apparent that the function of the soft palate is endangered by injury to the uvula. Admitting that some uvular tissue may be redundant, and that results of uvulotomy are not all unfortunate, the line between usefulness and uselessness is too indefinite to carelessly injure a useful organ. Some years ago I saw a patient who was a victim of too extensive uvulotomy, and ever since he has had difficulty in articulating and swallowing. Within the last few days I saw a woman, who was complaining of a nasal deficiency in speech, but no trouble swallowing. The uvula was absent, and on contracting the soft palate a notch was seen. The condition, while not endangering health, is incurable and a source of much annoyance. Its gravity is apparent when it is realized that it is a result of meddling surgery, and wholly unnecessary. Even when necessary, and it undoubtedly is at times, the advice given by Browne, to take off too much rather than too little, should be disregarded. The uvulotome, while a mechanically unsatisfactory instrument, is safer than the forceps and scissors. When stretched by the pull of the forceps too much tissue may be easily removed, and for such removal there is no remedy.

#### PROPAGANDA FOR REFORM.

**CAPSULES OF BISMUTH RESORCINOL COMPOUND.**—According to the label, each capsule of Bismuth Resorcinol Compound (Gross Drug Co., Inc., of New York City) contains bismuth subgallate, 2 grs.; resorcinol, 1 gr.; betanaphthol, 1/2 gr., and creosote (beechwood), 1 m. The preparation was declared

inadmissible to New and Nonofficial Remedies because unwarranted therapeutic claims were made for it; because the name is not descriptive of its composition, and because the combination of the stated drugs in fixed proportions is irrational. (Reports Council Pharmacy and Chemistry, 1917, p. 139.)

**COTARNIN.**—Cotarnin is an artificial alkaloid derived by oxidation from narcotin, by a process analogous to the derivation of hydrastinin from hydrastin (which again differs from narcotin only by an additional OCH<sub>3</sub> group). Cotarnin hydrochlorid is marketed as stypticin, and cotarnin phthalate as styptol. Cotarnin is used systemically mainly against uterine hemorrhage, especially in menstrual hemorrhage, endometritis and congestive conditions. It is ineffective against postpartum hemorrhage or bleeding from gross anatomic lesions, and probably also against hemorrhage in other internal organs. Local application of cotarnin in substance or concentrated solution has a direct vasoconstricting effect and is used in tooth extractions, epistaxis, etc. (*Jour. A. M. A.*, May 11, 1918, p. 1396.)

**ELIXIR NOVO-HEXAMINE.**—The A. M. A. Chemical Laboratory reports that Elixir Novo-Hexamine (Upsher Smith, St. Paul, Minn.) is not a "stable, palatable, potent preparation of Novo-Hexamine, an acid compound of hexamethylenamine," as claimed, but a flavored and colored solution of sodium acid phosphate and hexamethylenamine in diluted glycerol. The Council on Pharmacy and Chemistry considered the report of the laboratory and the advertising claims, and declared Elixir Novo-Hexamine inadmissible to New and Nonofficial Remedies because its composition is secret; because the ill-advised used by the public is invited; because unwarranted therapeutic claims are made for it; because the name is misleading, and because it is irrational to prescribe hexamethylenamine and sodium acid phosphate in fixed proportions. (Reports Council Pharmacy and Chemistry, 1917, p. 142.)

**FORMOSOL.** — Sunshine's Formosol (The Formosol Chemical Co., Cleveland, Ohio) is claimed to contain 18 per cent formaldehyde in a solution of soap. The preparation was refused recognition by the Council on Pharmacy and Chemistry because it was advertised indirectly to the public and because unwarranted therapeutic claims were made for it. (Reports Council Pharmacy and Chemistry, 1917, p. 145.)

**KALAK WATER.** — Kalak Water (The Kalak Water Co., Inc., New York) is a carbonated, artificial mineral water, said to contain in one million parts sodium carbonate, 4,049.0; sodium phosphate, 238.5; sodium chlorid, 806.3; calcium carbonate, 578.2; magnesium carbonate, 48.9, and potassium chlorid, 47.9. In view of the false and absurd claims made, the Council on Pharmacy and Chemistry declared Kalak Water inadmissible to New and Nonofficial Remedies. (Reports Council Pharmacy and Chemistry, 1917, p. 148.)

**MAYR'S WONDERFUL STOMACH REMEDY.** — This is a "patent medicine" adaptation of the old "fake gallstone" trick, which consists of selling large doses of olive or other oil and a saline cathartic. The result of taking this combination is the passage of a number of soapy concretions which the victim is persuaded to believe are gallstones. In 1915 Mayr was convicted under the Federal Food and Drugs Act for making false and fraudulent claims for his "remedy." As the Food and Drugs Act applies only to the packages of a preparation and not to store window displays and newspaper advertising, Mayr has revised the labels, etc., for his "patent medicine," but still makes misleading claims elsewhere. (*Jour. A. M. A.*, May 11, 1918, p. 1393.)

**PYOCYANEUS BACILLUS VACCINE.** — When this vaccine was admitted to New and Nonofficial Remedies in 1910 it gave promise of having therapeutic value. Now the firms whose products are described in New and Nonofficial Remedies advise the Council on Pharmacy and Chemistry that they have ceased to make the vaccine because of lack of

demand. Holding the lack of demand as evidence that the vaccine had proved without value, the Council directed its omission from New and Nonofficial Remedies. (*Jour. A. M. A.*, May 18, 1918, p. 1496.)

**THE DR. CHASE COMPANY.** — A fraud order prohibiting the use of the mails has been issued by the postoffice department against the Dr. Chase Company. This patent medicine concern sold three remedies—pills—which, before the Food and Drugs Act made lying on the label irksome if not expensive, were known, respectively, as "Dr. Chase's Blood and Nerve Food," "Dr. Chase's Kidney Food" and "Dr. Chase's Liver Food." Since the enactment of the Food and Drugs Act, however, the term "food" in the name of the nostrums has been changed to "tablets" for obvious reasons. In 1917 K. E. Hafer, the proprietor of the Dr. Chase Company, was fined under the Food and Drugs Act for misbranding. (*Jour. A. M. A.*, May 25, 1918, p. 1557.)

**SYPHILODOL.** — According to the French Medicinal Company, Inc., which markets the product, Syphilodol "is a synthetic chemical product of silver, arsenic and antimony \* \* \* ." Nowhere in the advertising matter is there a more comprehensive statement regarding the composition of this "new synthetic" than that just quoted. The product is being examined in the A. M. A. Chemical Laboratory: the examination having advanced sufficiently to show that Syphilodol contains considerable quantities of mercury. Although the advertising leaflet claims that the preparation is "the formula of the late Dr. Alfred Fournier of Paris" and has been exhaustively tested by Metchnikoff, a careful search of French medical journals fails to show any report on Syphilodol. (*Jour. A. M. A.*, Feb. 23, 1918, p. 559.)

**TROUSSEAU'S WINE.** — This obsolete combination of drugs acting on the heart and kidneys is made by maceration of digitalis, squill and juniper berries in wine and alcohol, and adding potassium acetate to the expressed liquid. (*Jour. A. M. A.*, Feb. 23, 1918, p. 559.)



## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or P. O. Box 16, Jacksonville, Fla., U. S. A.

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## SURGEON-GENERAL GORGAS AND THE RESPONSIBILITY OF THE MEDICAL DEPARTMENT OF THE ARMY.

No other branch of the Army is nearer the hearts of the people in time of war than the Medical Department. Fathers and mothers whose sons have enlisted may reconcile themselves if these sons are killed in battle; but if they have reason to fear that their sons have been neglected when sick or wounded, they develop a spirit of bitterness for which there can be no antidote. This natural attitude of mind is more or less apparent in all wars. A mother may bear with pride the news of the death of her son struck down in a charge or while stubbornly resisting an advancing foe; there is no consolation when she has reason to believe his death unnecessary, or that his health was not guarded by every known agency. If he dies from disease, as many soldiers must, she wishes to feel that kindness, intelligence and skill were at his service, and that the best of human effort was put forth in the endeavor to save him. If she realizes that he had every aid in his extremity that he could have enjoyed at home, she consoles herself, knowing full well that death must come to all.

While failure of the Medical Corps in the prosecution of war leads to grave disaffection at home, it has an even more serious effect on the morale of the Army itself. The soldier may bear great discomfort in his quarters or on the march—he may even court death on the battlefield—but he expects the best of care, sympathetic and kindly attention, and competent medical skill when he is sick or wounded. In this he is fully within his rights. When these helps fail, he becomes discouraged and even the ardor of patriotism fails to sustain him. Individually he becomes morose and complaining and in the mass inefficient. An army may be decimated by the missiles of the enemy and not only retain its courage, but become contemptuous of danger and death; when wasted by disease, however, or when its wounded soldiers are neglected

on the field, it ceases to be an efficient fighting machine.

The disastrous effects of inadequate protection of the health and life of the soldier are not confined to disaffection at home and demoralization in the ranks; for disaffection and demoralization, even when moderately felt, lead to a great reduction in the fighting strength and the combative spirit. All nations engaged in this war realize the vital importance of the medical service and have provided liberally for its equipment, personnel and maintenance. In the European armies, those of our allies and those of our enemies, medical officers have been given higher rank, invested with more authority and held to greater responsibility than has been known at any time in the past. The medical service has responded most satisfactorily to these advancements in honor, trust and duty, and with the exception of the shameful failure of line officers to heed the reasonable requests of the Medical Corps in the Mesopotamian campaign, there has been no cause for complaint.

So far as we have advanced in this war, there is no ground for serious complaint of or by the medical service. The President of the United States has recommended advanced rank and authority for medical officers, and at the present writing it seems that both houses of Congress are in sympathy with this request. Appropriations have been liberal and, best of all, the Medical Department has so guarded the health of our soldiers that no army, even one-tenth the size of ours, has ever been mobilized with sickness and death rates so low. Indeed, so far as we know, no army of raw troops has been assembled with the death rate calculated for all ages as low as that of the civilian population from which the soldiers have been drawn. In this country this is about 14 per thousand annually. In the Spanish-American War the death rate from disease greatly exceeded this figure, and ran above 20 per thousand. During the six winter months of 1917-1918, the annual death rate among all soldiers in this country was 9.1 per thousand. In many

camps the death rate has been lower than in the same age group in those sections of the country from which the troops have come.

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This, in brief, pictures the responsibility of the Medical Department of the Army. It is a responsibility which it gladly assumes. It may promise without a tinge of doubt that it will do its utmost to safeguard the morals, the health and the lives of our soldiers. As we write, there stands out the prominent fact that in this work the Medical Department has had as a leader a man who has the respect and confidence of all the American people and of all the scientists of the world.

The public, and the medical profession especially, are fortunate in having at the head of the Medical Department of the Army, in the present crisis, Surgeon-General Gorgas. General Gorgas, renowned for his successful combat with yellow fever, malaria and septic pneumonia on the Canal Zone, the work for which he has received the highest recognition among scientists and the people in general, has had a bigger problem among the troops of our country during the past winter and has achieved the same degree of success. His reputation will now include not only his remarkable record on the Canal Zone, in Havana and in South Africa, but also his efforts and the results in our camps during the past winter. He has commanded in our first great battle of this war, a battle in which more than a million men were engaged against dangerous diseases; and he has won a great victory.

Few men carry greater responsibilities than does General Gorgas. General Pershing in France must have more, and still more soldiers. Every unfit man who reaches him is a burden, not a help, and not only fails to add to his fighting strength but lessens it. Moreover, even the fit who reach France must be kept fit, and this burden also lies on the shoulders of General Gorgas. Still further, he must care for the wounded, return to the fighting line those whom medical and surgical skill can speedily restore, and bring back home those more seriously injured and

so rehabilitate them that they may return to civil life in the greatest possible comfort and with the least possible dependence on the assistance of others. His tasks are numerous and varied, but in the execution of them he may utilize his long experience and the wisdom it has given him. Moreover, his tasks will be performed with the most sincere sympathy for those involved. In the accomplishment of these duties every specialty in preventive and restorative medicine must be used. That General Gorgas has recognized this to the fullest extent is shown by his calling to his assistance many eminent men in every branch of the healing art. Indeed, he did not have to call, for they came and asked if they could render assistance. The readiness with which the very cream of our profession have left the comforts and attractions of their homes, disregarded their own financial and professional interests, shut their eyes to what it may cost them and their families, and offered their services, is due not only to patriotism, but also to their respect for, and admiration of, General Gorgas. They have rendered him the highest tribute that has ever come to a member of our profession. With General Gorgas at the head, the medical profession stands ready to fill the medical quota for any number of millions of men the President of the United States may call to arms.—*Jour. A. M. A.*

#### COUNCIL OF NATIONAL DEFENSE.

*Some of the activities and interests of the General Medical Board of the Council of National Defense, April, 1917—April, 1918, as reported at the Annual Meeting, Sunday, May 5, 1918, New Willard Hotel, Washington, D. C.*

The following statement, which is authorized by the Medical Section of the Council of National Defense, in a brief summary of the report of Dr. Franklin Martin, member of the Advisory Commission and chairman of the General Medical Board of the Council of National Defense, with mention of some of the leading interests and activities of the year

of the Board and of the Medical Section, was presented at the annual meeting of the General Medical Board, May 5, 1918:

##### *General.*

Secretary of War Baker, on April 2, 1917, authorized appointment of General Medical Board. Dr. Martin designated thirty-five physicians and surgeons, many of whom have since entered on active service abroad. Total now is seventy-seven. Executive Committee consists of Surgeons General of Army, Navy, and Public Health Service, Dr. Franklin Martin, Dr. W. J. Mayo, Dr. Wm. H. Welch, Dr. Victor C. Vaughan, Dr. F. F. Simpson, Rear Admiral Cary T. Grayson, and Dr. Wm. F. Snow, Secretary. The first meeting was held April 9, 1917.

Requested medical men returning from abroad to furnish information regarding conditions observed in medical services of allied armies; which information was carefully summarized for reference.

Responded to request of Surgeon General to assist in increasing enrollment in Medical Reserve Corps. Enrollments in M. R. C. have been increased from 1,800 in April, 1917, to over 21,000, of which 16,042 are on active duty.

Requested fifty medical societies to furnish lists of their members fitted to perform special work for government.

##### *Child Welfare.*

Formed Committee on Child Welfare, comprising representatives of several government departments, educational institutions and national organizations, to co-ordinate child welfare activities, and formulated program covering problems of the child up to school age, which program has been issued to the states through the medium of the States Council Section and the Woman's Committee of the Council of National Defense.

Appointed committees (a) to study best graphic methods of teaching child welfare; (b) to study food values necessary to children and prepare dietaries; (c) to report



best procedure as to midwife question in present war emergency, and (d) to consider advisability of investigation of institutions caring for children.

### *Civilian Cooperation in Combating Venereal Diseases.*

Developed joint conferences of medical and lay citizens in fifty cities, with officials, to discuss plans for venereal disease clinics or law enforcement measures.

Formulated list of eight measures essential to successful campaign against venereal diseases, and sent to State Boards of Health.

Appealed to State Pharmaceutical Associations for Boards of Pharmacy to assist in eliminating sale of nostrums.

Arranged trips for lecturers who aided Boards of Health in thirty states and stimulated them to more vigorous work.

Partially as a result of correspondence with State Boards of Health, twenty-six states have adopted measures requiring reporting of venereal diseases, nine have special venereal bureaus, fourteen provide free laboratory diagnosis, six provide arsphenamine, practically or absolutely free. Only seven states classified as complacent.

Partially as a result of letters to 1,000 mayors, forty-nine cities provide for isolation and treatment of venereal cases, fifty-one require reporting of venereal diseases, forty-three have clinics, seventy-eight are conducting educational work.

Informed editors of health bulletins and labor journals of details of campaign against venereal diseases.

Distributed printed material and sent personal and circular letters to thousands of persons in communities adjacent to army camps, enlisting their cooperation.

### *Dentistry.*

Appealed to dental profession through various dental associations, materially increasing enrollment in Dental Officers' Reserve Corps.

Instrumental in having military instruction included in curricula of dental colleges,

and in having applicants for enrollment in Dental Surgeons Corps specially trained.

Cooperated with manufacturers in having dental instruments and supplies standardized.

Secured volunteer services of civilian dental profession in eliminating dental disabilities of recruits.

Recommended improved courses in dental surgery in Army and Navy medical schools.

Initiated investigation as to relation of trench mouth disease to oral and general disease.

Dental Committee recommended higher rank for dentists in Army Dental Corps.

### *Hospitals.*

Recommended to general hospitals reorganization of staffs, in order to release as many as possible for Army and Navy service, and urged each person whose services could be spared to apply for appointment.

Hospitals classified exhaustively as to size, convenience to transportation, equipment, and all other details.

Investigated subject of portable hospitals, and recommended purchase of a limited number by the Surgeon General of the Army.

Classified and tabulated for use of Surgeon General's Office data as to private houses and large buildings offered for use as military hospitals.

### *Hygiene and Sanitation.*

Recommended to War and Navy Departments that zones around camps and cantonments be placed under military control in order to protect troops from venereal infections. Encouraged organization of Fossdick Commissions or Training Camp Activities.

Appointed subcommittees on drug addictions, alcoholic control, public health nursing, tuberculosis, and health statistics, which committees have assembled information and recommended definite sanitary measures for guidance of Army, Navy, Public Health Service, American Red Cross, and Civil Health Agencies.

Work of subcommittee on venereal disease has expanded, and it has become the Com-

mittee for Civilian Cooperation in Combating Venereal Diseases, a general committee of the General Medical Board.

#### *Industrial Medicine and Surgery.*

Instituted an Advisory Committee on Industrial Hygiene, comprising representatives from Public Health Service, Departments of Agriculture, Interior, Commerce, Labor, and of Organized Industry, Organized Labor, Organized Medicine, and Organized Industrial Medicine, for the purposes of providing against unnecessary human waste in industry and society during war, to offset drain of man-power from industry through raising of military forces to meet need for increased production, to avoid preventable deaths from accidents and disease, and to improve surroundings of workers.

#### *Legislation.*

Drafted section of Army Bill eliminating sale of alcoholic drinks and prostitution in five-mile zone around camps and cantonments; indorsed by Council of National Defense, and enacted into law within ten days of original rough draft.

Induced authorities to provide for enlistment of medical students of well-recognized schools in Enlisted Medical Reserve Corps, and completion of course before being called into military service. Similar effort made in aid of premedical students.

Instrumental in having American concerns licensed to manufacture salvarsan, and other German-owned medicinal preparations. Quantity previously sold for \$4.00, now furnished Government at \$1.00.

Made considerable effort to have rank of medical officers made commensurate with the service which the nation expects from the profession.

#### *Medical Schools.*

Urged students to continue medical education so that upon entering government service they might be fully trained; also urged students to apply for commissions in Medical Reserve Corps upon graduation.

Urged schools to release teachers for enrollment in Medical Reserve Corps.

Asked heads of educational institutions to advise premedical students to enroll in medical schools of their choice as soon as possible.

Asked medical schools to allow four-year students to substitute senior year in base hospital instead of school, if emergency arises.

#### *Medical War Manuals.*

Published four war manuals: 1, "Sanitation for Medical Officers", by Edward B. Vedder, M. D., Lieut. Col., M. C., U. S. A.; 2, "Notes for Army Medical Officers," by T. H. Goodwin, Lieut. Col., R. A. M. C.; 3, "Military Ophthalmic Surgery," by Allen Greenwood, Major, M. R. C., G. E. de Schweinitz, Major, M. R. C., and Walter R. Parker, Major, M. R. C., and 4, "Military Orthopedic Surgery," by the Orthopedic Council.

These also are ready for publication: "Surgery of the Zone of Advance," by George de Tarnowsky, Major, M. R. C.; "Notes on Military Surgery," by George W. Crile, Major, M. R. C., and "Lessons from the Enemy," by John McDill.

#### *Nursing.*

Instrumental in increasing by 20 per cent number of pupil nurses in training schools, by means of correspondence with college and school graduates, deans of women's colleges, school principals and Board of Education secretaries.

Distributed about 100,000 bulletins and leaflets for information of prospective students.

Made nation-wide survey of country's nursing resources, and urged heads of training schools and hospitals to increase their facilities.

Published series of twelve articles on nursing in newspapers throughout the country.

Instrumental in having nurses included in War Risk Insurance Law.

Secured evidence of need for military rank for nurses, and secured indorsements of this movement from many persons.

Conducted campaign for increasing number of candidates for nursing education.

Cooperated in preparing details of preparatory nursing course for college graduates at Vassar College.

Recommended to Surgeon General of the Army that increased accommodations for nurses be made at camps, and not less than one nurse be provided to six acutely ill men, that there be a reserve of not less than twenty-five nurses at each camp hospital, and that a qualified nurse tour military and naval hospitals to make observations; all of which recommendations have been favorably received. Miss Annie W. Goodrich appointed Inspector General of Nursing Service in all military hospitals in the United States and France.

Recommended to superintendents of training schools to speed instruction and hold final examinations and graduations early in 1918, and release graduates for government service.

Cooperated with Red Cross and with National Organization for Public Health Nursing in enrollment of public health nurses in office of Red Cross, and urged public health nursing agencies to release staff members for service in extra-cantonment zones and for rehabilitation work in France and Belgium.

Cooperated with Food Administration in having health nurses instructed in preparation of war-time food substitutes.

#### *Reeducation and Rehabilitation.*

Presented to Secretary of War plan for formation of Reconstruction Board, including representatives of Army, Navy, Public Health Service, Red Cross, Council of National Defense, Hospitals and Laboratories, Medicine and Surgery, Vocational Education, Labor and Industry. Secretary of War instructed Surgeon General to call conference and formulate plan. As a result bill was drafted providing for vocational rehabilitation and return to civil employment of soldiers and sailors disabled in line of duty.

#### *Research.*

Instituted investigation of conditions under which canned foods become deleterious.

Was instrumental in having University of Minnesota grow a supply of digitalis adequate for America's needs, to replace supply hitherto obtained from Germany.

Instituted tests of devices aimed to protect the ear from injuries by explosives.

Examined and card-indexed numerous antiseptics and disinfectants, furnishing all information to Medical Supply Department of the Army. Valuable cocaine substitutes and cheap disinfectants found usable. Silenced claims of vendors of large number of absolutely worthless preparations.

Placed subject of shell shock in hands of Dr. George W. Crile for study.

Instrumental in bringing into use several substitutes for ambrine, for treatment of burns.

Instituted study which led to discovery that various preparations of thromboplastin help prolong period for coagulation of blood.

Investigated various devices for preparation for sterilizing wounds and germ carriers.

Instituted study of processes for sterilizing drinking water which led to authoritative statement that use of chlorine is best means, chlorine now being used under all conditions.

Instrumental in having prepared authoritative review of war literature bearing upon injuries of the peripheral nerves.

Abstracted all obtainable literature on methods of destroying lice, and instituted experimental research.

Instrumental in having published critical review of methods and results of vaccination for smallpox.

Obtained from a noted French authority statement of results obtained by French investigators as to value of Widal test after vaccination for typhoid fever.

#### *Standardization.*

Held frequent conferences to study means by which production might be speeded, and demand for diverse types of appliances might be curtailed.



Conferences participated in by representatives of Army, Navy, Red Cross, Public Health Service, and manufacturers of surgical instruments and supplies. Result: Substantial increase in production of staple articles, standardization in types and issuance for four catalogues of staple medical and surgical instruments and supplies for use of Army, Navy and Red Cross.

#### *States' Activities.*

Obtained through State and County Committees names of physicians (a) available for service in the Medical Reserve Corps, (b) those not available because of physical disability, over-age (55), or because of home community need.

Requested cooperation of medical profession in asking aid of Senators and Congressmen for legislation in reference to advanced rank for medical officers.

Made survey of medical schools, as a result of which arrangements were made for enlistment of medical students of well-recognized schools in enlisted medical reserve corps and placing them on inactive list until completion of their medical education. Similar effort made in aid of premedical students.

Organized Volunteer Medical Service Corps for physicians ineligible to Medical Reserve Corps, because of physical disability, over-age, or essential home community need.

Prepared and mailed monthly to State and County Committees percentage tables of recommendations by Surgeon General for commissions in Medical Reserve Corps.

Cooperated with Provost Marshal General's Office in selecting members of Medical Reserve Corps as medical aides to governors. Formulated outline of duties of medical aides.

Cooperated in having representatives sent to forty-four states urging membership in Medical Reserve Corps.

Classified membership records of Medical Reserve Corps from code cards, a set being furnished for the Surgeon General's Office in Washington and a set for the representative of the Surgeon General with General Pershing's Army in France.

Made survey, through a subcommittee, of ophthalmologists of country, and requested those not needed for institutional and civic needs to join Medical Reserve Corps.

Same committee standardized methods of eye examinations. Held conference on re-education of blind soldiers, and conducted survey of workshops for the blind.

Made survey and classified, through a subcommittee, the otolaryngologists of country (brain, oral and plastic surgeons), requesting those available to join Medical Reserve Corps.

Recommended that specialists in head surgery be assigned to special duty in military hospitals; also that special hospitals be assigned for treatment of eye, ear, nose and throat cases; also recommended definite number of surgeons and assistants of each specialty, for chief hospitals and for each military division.

#### *Women Physicians.*

Prepared index and complete data as to all women physicians in the United States.

Prepared lists of anesthetists, laboratory workers, radiographers, sanitarians, specialists, and industrial surgeons, willing to serve.

Compiled data regarding recent graduates of thirty-five coeducational medical colleges.

Secured registration of 1,875 women physicians willing to serve—more than one-third of the total number in the United States.

OUR HONOR ROLL.

Our Honor Roll as published below now constitutes a grand total of one hundred and fifty-four physicians. They are divided in the services as follows: Medical Corps—Lieutenant Colonel, 1; Medical Corps, National Army—Lieutenant Colonel, 1; Medical Reserve Corps—Majors, 14; Captains, 29; 1st Lieutenants, 95; total, 140. United States Navy—Passed Assistant Surgeons, 2; Assistant Surgeons, 4; total, 6. National Guard United States (Fla.) —Majors, 3; Captain, 1; 1st Lieutenants, 4; total, 8.

MEDICAL CORPS, U. S. ARMY.

*Home Address.*

Lieut.-Colonel Joseph Y. Porter.....Key West

MEDICAL CORPS, NATIONAL ARMY.

Lieut.Colonel Raymond C. Turck.....Jacksonville

MEDICAL RESERVE CORPS.

Major Frank E. Artaud.....Key West  
Major M. H. Axline.....St. Petersburg  
Major John E. Boyd.....Jacksonville  
Major Frederick G. Barfield.....Jacksonville  
Major Chauncey L. Chase.....Fort Dade  
Major Stanley Erwin.....Jacksonville  
Major James B. Griffin.....St. Augustine  
Major H. H. Harris.....Jacksonville  
Major Graham E. Henson.....Jacksonville  
Major Frederick E. Jenkins.....Palatka  
Major Frank R. Maura.....Ojus  
Major Lucien B. Mitchell.....Tampa  
Major Harry Peyton.....Jacksonville  
Major George A. Plummer.....Key West  
Captain A. E. Acker.....Jacksonville  
Captain E. G. Birge.....Jacksonville  
Captain H. O. Black.....Jacksonville  
Captain Andrew R. Bond.....Tampa  
Captain O. L. Callahan.....Mt. Dora  
Captain T. Z. Cason.....Jacksonville  
Captain Lester J. Efrid.....Tampa  
Captain Albert H. Freeman.....Starke  
Captain Julian Gammon.....Jacksonville  
Captain J. Halton.....Sarasota  
Captain Henry Hanson.....Jacksonville  
Captain Maurice E. Heck.....St. Augustine  
Captain Samuel G. Hollingsworth.....Bradentown  
Captain Owen H. Kenan.....Palm Beach  
Captain S. M. R. Kennedy.....Pensacola  
Captain William W. Mills.....Miami  
Captain William B. Moon.....Lakeland  
Captain Frederick C. Moor.....Tallahassee  
Captain John MacDiarmid.....DeLand  
Captain R. B. McLaws.....Tampa  
Captain D. W. McMillan.....Pensacola  
Captain John D. McRae.....Tampa  
Captain Thomas A. Neal.....Sanford  
Captain James B. Parramore.....Jacksonville  
Captain James D. Pasco.....Jacksonville  
Captain J. Y. Porter, Jr.....Key West  
Captain G. M. Randall.....  
Captain M. B. Swift.....Orlando  
Captain Harry F. Watt.....Ocala  
1st Lieut. Daniel M. Adams.....Panama City

1st Lieut. Allen M. Ames.....Pensacola  
1st Lieut. C. A. Andrews.....Tampa  
1st Lieut. Harold M. Beardall.....Orlando  
1st Lieut. Henry P. Bevis.....Arcadia  
1st Lieut. James H. Bickerstaff.....Pensacola  
1st Lieut. John B. Black.....Jacksonville  
1st Lieut. Everard Blackshear.....Citra  
1st Lieut. Louis B. Bouchelle.....DeLand  
1st Lieut. John T. Bradshaw.....San Antonio  
1st Lieut. Percy H. Brigham.....Branford  
1st Lieut. Herbert L. Bryans.....Pensacola  
1st Lieut. B. A. Burks.....Titusville  
1st Lieut. Fay A. Cameron.....Tampa  
1st Lieut. Chauncey L. Chase.....Fort Dade  
1st Lieut. Joseph H. Chiles.....Cleremont  
1st Lieut. William A. Clark.....Pine Barren  
1st Lieut. J. S. Coker.....Gardner  
1st Lieut. Henry B. Cordes.....Jacksonville  
1st Lieut. Charles S. Cooper.....St. Cloud  
1st Lieut. Wallace P. Crigler.....Ocala  
1st Lieut. T. G. Croft.....Jacksonville  
1st Lieut. Clinton W. D'Alemberte.....Pensacola  
1st Lieut. James S. Davidson.....Clearwater  
1st Lieut. Kenneth McC. Davis.....Westbay  
1st Lieut. Gaston Day.....Jacksonville  
1st Lieut. L. B. Dickinson.....Clearwater  
1st Lieut. George W. Dupree.....Blue Creek  
1st Lieut. William T. Elmore.....Gainesville  
1st Lieut. Orin O. Feaster.....Mulberry  
1st Lieut. Neco L. Gachet.....Century  
1st Lieut. Claude V. Gautier.....Passagrille  
1st Lieut. Hugh St. C. Geiger.....Kissimmee  
1st Lieut. H. M. Ginsberg.....Pensacola  
1st Lieut. Paul Goss.....Mulberry  
1st Lieut. O. F. Green.....Mayo  
1st Lieut. John D. Griffin.....Lakeland  
1st Lieut. G. H. Gwynn, Jr.....Tallahassee  
1st Lieut. Humphrey Gwynn.....Tallahassee  
1st Lieut. J. H. Hall.....Sopchoppy  
1st Lieut. John Halliday.....Tampa  
1st Lieut. Drew R. Handley.....Jacksonville  
1st Lieut. MacMiller Harrison.....Palmetto  
1st Lieut. John R. Hereford.....Fort Dade  
1st Lieut. Frank P. Hixon.....Pensacola  
1st Lieut. John C. Holley.....Pace  
1st Lieut. H. F. Horne.....Jacksonville  
1st Lieut. Roy Howe.....Daytona  
1st Lieut. A. L. Izlar.....Ocala  
1st Lieut. Edward Jelks.....Jacksonville  
1st Lieut. Charles L. Jennings.....Jacksonville  
1st Lieut. J. K. Johnston.....Tallahassee  
1st Lieut. Charles L. Kennon.....Jacksonville  
1st Lieut. William J. Lancaster.....Tampa  
1st Lieut. Richard Jeffers.....Lakeland  
1st Lieut. Milford Levy.....Tallahassee  
1st Lieut. John P. Long.....Lake City  
1st Lieut. John W. McClane.....St. Petersburg  
1st Lieut. George S. McClellan.....Wellborn  
1st Lieut. James R. McEachren.....Monticello  
1st Lieut. Harry B. McEuen.....Quincy  
1st Lieut. William G. McKay.....Jacksonville  
1st Lieut. Albert C. McKenzie.....Jacksonville  
1st Lieut. Earle H. McRae.....Tampa  
1st Lieut. H. R. Mills.....Tampa  
1st Lieut. George M. Mitchell.....Jacksonville  
1st Lieut. Joseph A. Mixon.....Pensacola  
1st Lieut. H. P. Newman.....Bartow  
1st Lieut. John A. Newnham.....Cleremont  
1st Lieut. John K. Norwood.....Jacksonville  
1st Lieut. Bascom H. Palmer.....Tampa  
1st Lieut. Henry E. Parnell.....Fort Myers  
1st Lieut. Archie R. Parrott.....Jacksonville

APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.

.....  
....., 191.....

Sir :

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....  
.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country.....  
.....
4. When and where were you naturalized? (For applicants of alien birth only.).....  
.....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....  
.....
10. If either parent or brother or sister has died, state cause and age in each case:.....  
.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....  
.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc.:.....  
.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates: .....  
.....
16. With what ancient or modern languages or branches of science are you acquainted?.....  
.....

\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.



17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result: \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.

1st Lieut. James L. Pennington.....	Fountain
1st Lieut. J. O. Philips .....	Worthington Springs
1st Lieut. William H. Pickett.....	Gainesville
1st Lieut. Harper L. Proctor .....	Jacksonville
1st Lieut. Marion E. Quina .....	Pensacola
1st Lieut. Shaler A. Richardson .....	Jacksonville
1st Lieut. Dwight M. Rivers.....	Lake City
1st Lieut. E. T. Sellers .....	Jacksonville
1st Lieut. George W. Sherouse .....	Campville
1st Lieut. E. E. Strickland .....	Micosukie
1st Lieut. Baldwin S. Stutts .....	Port St. Joe
1st Lieut. G. C. Tillman .....	Gainesville
1st Lieut. W. J. Vinson .....	Tarpon Springs
1st Lieut. Harry C. VonDahm.....	Jacksonville
1st Lieut. Adam C. Walkup .....	McIntosh
1st Lieut. Archie Watson .....	Live Oak
1st Lieut. B. L. Whitten .....	Fort Pierce
1st Lieut. John M. Whitfield .....	Malone
1st Lieut. William E. Whitlock.....	Fort White
1st Lieut. Charlton C. Whittle .....	Nocatee
1st Lieut. Daniel B. Williams .....	Lake City
1st Lieut. Albert H. Wilkinson.....	Jacksonville

THE NAVY.

Passed Assistant Surgeon W. P. Dey..	Jacksonville
Assistant Surgeon Thomas S. Field....	Jacksonville
Assistant Surgeon Boyd Gilbert.....	Pensacola
Assistant Surgeon R. P. Henderson.....	Tampa
Passed Asst. Surgeon J. Knox Simpson,	Jacksonville
Assistant Surgeon D. C. Thompson.....	Pensacola

NATIONAL GUARD UNITED STATES (FLA.).	
Major Lorin Green .....	Jacksonville
Major Ralph Green .....	Jacksonville
Major James H. Livingston .....	Jacksonville
Captain W. J. Buck .....	Gainesville
1st Lieut. Daniel C. Campbell.....	Marianna
1st Lieut. John R. Hawkins .....	Williston
1st Lieut. Z. V. Johnson .....	Milton
1st Lieut. J. M. Mitchell .....	Millville

MANIFEST PULMONARY  
TUBERCULOSIS.

G. E. Bushnell, Colonel, United States Army, Retired, publishes an article in the *American Review of Tuberculosis*, for May, on the diagnosis and prognosis of cases of tuberculosis in which there is no question of the existence of the disease. For the sake of aiding the inexperienced and of avoiding confusing qualifications the statements are kept as simple as possible and those points stressed which should be particularly borne in mind in the study of the tuberculosis lesion.

*Fibrosis:* With tuberculous infiltration and absorption of the products of the focus, the body tissues gain a new reactivity. If the absorption is not too great they are able to combat the infection and scar tissue is formed about the focus. Fibrosis may be very ex-

tensive and even involve a whole lung. It may be looked upon as evidence of a long standing lesion and of immunity of the individual. The encapsulation is not an absolute mechanical barrier, however, as evidenced by the reactivation of ancient foci in cachectic conditions.

*Caseation:* Caseous foci produce a wet lesion. They may be surrounded by dense fibrous tissue.

*Breath Sounds:* Observation of the breath sounds must be correlated with that of the patient's general condition, lest unjustifiably favorable conclusions be drawn.

*Rales:* The various kinds of rales and their relation to different pathological conditions are taken up in detail. Rales constitute the auscultatory evidence of inflammatory reaction to the poisons of the tubercle and are the best evidence that the lesion is resisting its focus.

*Symptoms:* These should be considered in conjunction with the rales. Continued observation is necessary to a final determination of the condition of the patient.

*Topical Diagnosis:* Civilized man has a partial immunity against tuberculosis. In about 70 per cent the disease is never recognized clinically and in the remaining 30 per cent it appears in forms not characteristic of primary tuberculosis. It is due to a temporary or permanent, complete or partial loss of immunity.

*Normal Apex:* Observation here excludes well-marked chronic disease of the upper lung but it does not exclude acute forms.

*Apical Tuberculosis:* In the more resistant cases the first manifestation is in the apex. Progressively less resistant are the forms in which the initial foci coalesce into one or more large foci which may become encapsulated or lead to cavitation—more properly denominated tuberculosis of the upper lobe. Apical lesions in the strict sense are of importance in diagnosis only as respects the decision as to whether a lesion is present at all. From the fact that the apical lesion is usually found in an arrested state it is often not recognized and the latter extensions lower

downward in the upper lobe are taken to be the first of the superficial lesions.

*Upper Lobe Lesions:* Often the tuberculous lesion of the upper lobe has consisted in the deposition of a few tubercles which remain discreet, become fibrous or calcified, or if small disappear entirely and the existence of a lesion is to be determined solely by the signs which point to diffuse thickening of the connective tissue framework. Where pneumonia occurs the lesion usually presents itself as a chronic one. Less chronic and less indurated small lesions of the upper lobe are detected with greater difficulty. There is as much difference in the severity of even arrested lesions as exists between a scorch of the skin and a third degree burn.

*Bilateral Type of Peribronchial Tuberculosis:* In this type there is fibroid induration and thickening along the normal course of the bronchi and blood vessels, the induration extending well into the lower lung on each side. In some cases the X-ray shadows are massive and the course of the tubes and vessels no longer apparent. There has been a strong reaction to the presence of widely spread tubercle bacilli and bacillary poisons. The disseminated tubercles may have become calcified or fibrous at the time of examination and therefore probably not likely to be of harm or they may be a source of great danger.

*Acute Peribronchial Tuberculosis:* This is apt to occur on the hitherto healthy side opposite an old and apparently nearly or quite healed lesion. The masses of tubercle are so thickly grouped about the bronchi that the process progresses toward the lumen of the bronchus, with or without actual perforation. There is incessant cough without results which generally terminate in vomiting. Morphine may be helpful for a while but the patient is speedily worn out.

*Large Sluggish Lesions:* The most salient characteristic of a lesion of this class is its development according to law — terminated by the immunity of the individual and the relative mobility of the part. Hence we expect cavities and fibrous tissue at the summit

followed by progressively smaller and more numerous lesions as the mobility of the lung increases downward and the lapses of immunity become more serious. In another class of lesion two types are distinguished. The first consists essentially in a disseminated fibrosis which from its nature does not give very sharply marked signs. The second class of cases is found among patients which have been under favorable conditions but have been slowly retrogressing. Here the difficulties of diagnosis are largely due to the presence of extensive plastic exudates which act in various ways to obscure the physical signs.

There is one class apparently similar to those just described which presents great difficulty in diagnosis and prognosis where there is all the evidence of advanced disease but the patient's general health is good. The determination of such a case is made by the disassociation of signs and symptoms. Here as in all advanced cases, symptoms furnish the surest clue to the prognosis.

*The Cavity:* A cavity may be superficial or deep, open or closed. If surrounded by air containing lung substance the signs may be much obscured, whereas in the more usual form in which the wall is little more than the two adherent layers of the pleura firmly adherent to the ribs the cavity sounds are conducted with startling distinctness. A large cavity is always more or less a wet cavity. Small cavities are difficult of diagnosis. A closed cavity gives no certain physical signs. A full cavity, equivalent to an abscess may be suspected if its location and weight are such as to pull upon the pleura and cause the characteristic "pleural" reflex cough. A deep cavity presents some difficulties of diagnosis. A variety of this is the serpiginous cavity, a narrow sinuous tube extending far down into the lung. With the extending downward cavitation hemorrhage is likely to ensue, the blood is difficult to raise and for the greater part infiltrates the surrounding lung causing cyanosis and death.

*The Large Superficial Lesion:* Typically this lesion is made up of a cavity surrounded



by abundant fibrous tissue above, below this a few large isolated tubercles, still farther down numerous small tubercles. It represents at once three stages of development and denotes a progress of years. The prognosis depends upon the kind and number of rales in the lower parts of the lesion and whether or not there is evidence there of circumscription of the process from the presence of fibrous tissue. A lesion of this kind should be studied to determine the relative age of its parts and the topographical distribution of caseous and fibrous tissue.

*Peribronchial Extension in the Same Lung:* In the upper lobe the force of inspiration is directed toward the ribs and tuberculous lesions are most marked or only existent near the surface of the lung. But in the lower chest the movements of the diaphragm have more influence upon the lymph supply and the invasion is directed downward. The active motion of the expansile base does not, however, permit the establishment of tuberculous foci unless active motion is prevented by pleural adhesions. Extensions in the lower lobe are apt to involve the entire course of the bronchus. What we judge of as superficial extensions of but slight extent are here really the outward manifestation of a very considerable process, the greater part of which runs its course in the deep lung.

*Lesions of the Other Lung:* All pulmonary tuberculosis is essentially bilateral, so far at least as the deep lung is concerned. As a rule lesions of the lung secondarily involved are larger and more acute than those of the side first affected. If a patient with an arrested lesion presents signs of constitutional impairment especial care should be taken to examine the opposite side.

*Miliary Tuberculosis:* A better name would be disseminated hæmatogenous tuberculosis and it should be reserved for cases in which there is a large or a universal dissemination often from an old and apparently insignificant focus of minute tubercles which constitute the principal disease. The point upon which especial emphasis should be laid is, that the initial condition which is the real

cause of miliary tuberculosis is the complete failure of immunity which allows collections of tubercle bacilli to be set free and to establish everywhere new colonies. The dissemination may be sparse or dense. Their characteristic feature is their irregularity of dissemination.—*Bushnell, George E.: Manifest Pulmonary Tuberculosis, Am. Rev. Tub., 1918, Vol. 2, No. 3.*

## VOCATIONAL REHABILITATION OF THE DISABLED SOLDIER.

*The Journal* has frequently stated that the most important future work connected with the war is the rehabilitation and placement in a vocation of the disabled. It has stated that this work properly should come under the supervision and direction of the Surgeon-General of the Army or the Navy, as the case might be. Recently Senator Smith of Georgia introduced a bill which looked to the transference of some of this work to the Federal Board for Vocational Education. According to the original bill, this work, while theoretically under the supervision of the Surgeon-General, would in reality have been under the supervision of this Federal Board. This, of course, would have been a serious handicap to good work. As the bill passed the Senate, it was so modified as to make the measure a fairly satisfactory one. It must be recognized that an entire program which shall deal with the disabled soldier in an effective way must involve his medical and surgical treatment, whatever reeducation may be necessary, and his final placement or after-care. While the Surgeon-General of the Army had facilities to do all of this work, and, in fact, had worked out a program, other federal agencies also were prepared to do part of the work supplementary to the medical and surgical treatment. The bill leaves the soldier, or sailor, under the entire authority of the War Department or Navy Department—that is, in the Medical Department of the Army or Navy—until discharged from the service. The Surgeon-General may deal with the soldier in an attempt to cure him, or as

nearly so as the man's disabilities permit, without outside interference. The bill provides that no "vocational teaching shall be carried on in any of the hospitals until the medical authorities certify that the condition of the patient is such as to justify such teaching"; also that "the plan may be established between the War and the Navy Department and the Federal Board for vocational education whereby these departments will act in an advisory capacity with the board in the care of the health of the soldier after his discharge." Necessarily, if the program as outlined by the bill is to be carried out in a satisfactory manner, there must be hearty cooperation between the Federal Board and the Surgeon-Generals of the Army and of the Navy. There is no reason to suppose that this cooperation will not be entered into fully by these different interests, and to the ultimate, best advantage of the disabled soldier.

—*Jour. A. M. A.*

---

### THE PEORIA OUTBREAK.

It is disappointing to find that widespread epidemics due to a sewage-contaminated water supply still occur with relative frequency in large and civilized communities. Peoria is the third large Illinois city to suffer from a visitation of this sort within a few years, similar outbreaks having occurred at Rockford and Quincy a few years ago. In the last named cities the outbreak was clearly traced to the water supply, and the circumstances leading up to the occurrence were fully investigated. In both Rockford and Quincy the outbreak of gastro-intestinal disease was followed by one of typhoid fever. It is yet too early to learn whether Peoria will be afflicted in like manner, but the health authorities in that city must be awaiting developments with anxiety. In the majority of such outbreaks everywhere typhoid with its relatively long period of incubation has been a sequel to the more sudden and more extensive as well as more transient epidemic of gastro-enteritis.

Owing to the fact that no complete in-

vestigation and report on the Peoria situation have yet been made by the local authorities, we are not in a position to state exactly how the water contamination occurred. The fact that the water company is privately owned may perhaps explain in part the difficulties of carrying through a complete investigation. It can hardly be believed, however, that the Peoria authorities will allow the matter to rest here, particularly with the shadow of a possible typhoid epidemic hanging over them. The citizens of Peoria will doubtless demand that a searching inquiry be made, and that so far as practicable the conditions at the water works and the circumstances preceding the outbreak be brought to light.

The state of Illinois has for some years maintained an expert staff and excellent facilities for water examination in connection with the State Water Survey, with headquarters at the University of Illinois. There is also a well organized Illinois Water Supply Association, with membership composed of the various water works superintendents and other officials. It is somewhat singular that three of the most serious outbreaks of water-borne disease that have occurred in this country should have occurred in this state. Both the Rockford and the Quincy epidemics were due to something approaching mismanagement of the water supply systems, and from the information furnished in the report of our special investigator published last week it may be conjectured that the Peoria outbreak may have been due to some form of carelessness or negligence on the part of the responsible authorities.

It is somewhat surprising that in a city the size of Peoria an efficient municipal health organization should not be provided. We understand that the Peoria health officer is not a full-time appointee, and that no systematic oversight of the bacterial condition of the water supply has been practiced. In Peoria as in many other cities there have doubtless been some unsettling changes in the office of the health commissioner, as a

result of the shifting of personnel necessitated by the war; but the health of a thriving city is too important to be jeopardized in this way except in dire need. There seems little doubt that Peoria, like many other cities of its class, is mistaken in supposing that the health work of the city can be properly administered with part-time service and with insufficient staff and appropriations. There is a kind of efficiency just as necessary at this time in civil life as in the military camps. If Peoria reaps an aftermath of typhoid with its roll of deaths, the appeal to the imagination of the average citizen may be greater than if no further development takes place; but the outbreak, as we now know about it, must be sufficiently impressive to the responsible authorities. In public health affairs, eternal vigilance is the price of safety.—*Journal A. M. A.*, March 9, 1918.

### THE ILLEGITIMATE BABY'S RIGHTS.

The rights of illegitimate children and the state's responsibility for seeing that every child, no matter what his parentage, has the nurture, protection, and education essential to his usefulness as a citizen are for the first time given complete national recognition in the Norwegian laws concerning illegitimate children, according to a report issued today by the Children's Bureau of the U. S. Department of Labor.

These laws make the state instead of the mother responsible for establishing paternity. The state holds both parents equally and continuously responsible for the illegitimate child—"The child shall be entitled to bringing up, maintenance, training, and education, from both its father and its mother." The report contains a translation of the several Norwegian laws, with amendments, on illegitimate children and their care. A history of the efforts through which the legislation was secured is given in the introduction.

The attitude which looks upon illegitimacy as a child-welfare problem that must be

solved for the sake of the child and of the state is exemplified by this Norwegian legislation. In connection with its studies of the bearing of the war upon child-welfare the Children's Bureau examined the evidence obtainable, but could not find that it justified the statements that have been circulated of widespread increase in illegitimacy since the war. The Bureau believes, however, that the needs of the illegitimate child must be considered in the Children's Year campaign "to save 100,000 children's lives during the second year of the war and to get a square deal for children."

### NEW AND NONOFFICIAL REMEDIES.

**CHLORCOSANE.**—A liquid, chlorinated paraffin, containing its chlorine in stable (non-active) combination. It is used as a solvent for dichloramine-T and is itself without therapeutic action.

**CHLORCOSANE-CALCO.**—A brand of chlorcosane containing from 31 to 35 per cent of combined chlorine. The Calco Chemical Co., Bound Brook, N. J.

**CHLORCOSANE-MONSANTO.**—A brand of chlorcosane containing from 27 to 30 per cent of combined chlorine. Monsanto Chemical Co., St. Louis, Mo. (*Jour. A. M. A.*, May 18, 1918, p. 1459.)

Geo. W. Brady & Co.: Barium Suphate-Brady for Roentgen-Ray Work.

Johnson and Johnson: Chlorine-Soda Ampoules.

Lederle Antitoxin Laboratories: Antipneumococcic Serum, Type I.

Monsanto Chemical Works: Chlorcosane-Monsanto.

Morgenstern & Company: Acid Phenylcinch.-Morgenstern; Acid Phenylcinch.-Morgenstern Tablets; Sodium Phenylcinch.-Water-Morgenstern.

Parke, Davis & Company: Antipneumococcic Serum, Type I.

Rector Chemical Company, Inc.: Procaine-Rector.

E. R. Squibb and Sons: Antipneumococcic Serum, Type I.



## Publisher's Notes

### PROCAINE AND NOVOCAINE IDENTICAL.

*To the Editor:*

It appears that in certain quarters the attitude is taken that the local anesthetic sold as Procaine is not identical with that marketed as Novocaine. The Subcommittee on Synthetic Drugs of the National Research Council believes it important that this misunderstanding should be corrected and hence offers the following explanation:

The monohydrochloride of para-amino-benzoyldiethyl-amino-ethanol, which was formerly made in Germany by the Farbwerke, vorm. Meister, Lucius and Bruening, Hoechst A. M., and sold under the trade-marked name Novocaine, is now manufactured in the United States. Under the provisions of the Trading with the Enemy Act, the Federal Trade Commission has taken over the patent that gave monopoly for the manufacture and sale of the local anesthetic to the German corporation, and has issued licenses to American concerns for the manufacture of the product. This license makes it a condition that the product first introduced under the proprietary name "Novocaine" shall be called Procaine, and that it shall in every way be the same as the article formerly obtained from Germany. To insure this identity with the German Novocaine, the Federal Trade Commission has submitted the product of each firm licensed to the A. M. A. Chemical Laboratory to establish its chemical identity and purity, and to the Cornell pharmacologist, Dr. R. A. Hatcher, to determine that it was not unduly toxic.

So far, the following firms have been licensed to manufacture and sell Procaine:

The Abbott Laboratories, Ravenswood, Chicago.

Farbwerke-Hoechst Company, New York, N. Y.

Rector Chemical Co., Inc., New York, N. Y.

Calco Chemical Company, Bound Brook, N. J.

Of these, the first three firms are offering their products for sale at this time, and have secured their admission to New and Non-official Remedies as brands of Procaine which comply with the New and Nonofficial Remedies standards.

While all firms are required to sell their product under the official name "Procaine," the Farbwerke-Hoechst Company is permitted to use the trade designation "Novocaine" in addition, since it holds the right to this designation by virtue of trademark registration.

In conclusion: Procaine is identical with the substance first introduced as Novocaine. In the interest of rational nomenclature, the first term should be used in prescriptions and scientific contributions. If it is deemed necessary to designate the product of a particular firm, this may be done by writing Procaine-Abbott, Procaine-Rector, or Procaine-Farbwerke (or Procaine-Novocaine brand).

Yours truly,

JULIUS STIEGLITZ, *Chairman*  
*Subcommittee on Synthetic Drugs, National Research Council.*

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Annual Meeting at Miami, May 1919

# THE JOURNAL

OF THE

# Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME IV  
No. 12

St. Augustine and Jacksonville, Fla., June, 1918

Yearly Subscription, \$1.50  
Single Copy, 15c.

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# THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume IV

St. Augustine and Jacksonville, Florida, June, 1918

Number 12

## Proceedings of the Forty-fifth Annual Meeting

OF THE FLORIDA MEDICAL ASSOCIATION, IN SESSION  
TWO DAYS, AT TAMPA, FLORIDA, MAY 15 AND 16, 1918

The forty-fifth annual meeting of the Florida Medical Association was called to order in the auditorium of the Hillsboro Hotel, Tampa, at 10 a. m., May 15th, by Doctor J. Brown Wallace, Chairman of the Committee on Arrangements.

After prayer had been offered, the Hon. J. M. Gwynn delivered an address of welcome in behalf of the city of Tampa and the local profession. Doctor Graham E. Henson, Secretary, responded in behalf of the Association.

The President, Doctor Ralph N. Green, assumed the chair, the following reports being read by the Secretary:

### *Report of the Executive Committee.*

Your Executive Committee have had nothing of moment referred to them during the past year. The chairman of the committee, Doctor F. F. Ferris, of Apalachicola, is now in the military service. The Association has some outstanding debts that should be retired. Inasmuch as some two hundred members of the organization are in the public services, and that the revenues of the organization are reduced to a considerable extent, your committee recommends that a war tax of one dollar and a half be levied against each member not in the military or naval services, and that the county secretaries be requested to make earnest effort to collect this assessment. It may not be necessary to continue this additional assessment, and it is not conceivable that it will work any hardship on any individual. On the other hand the adoption and carrying out of the recommendation will assure the satisfactory conduct of the affairs of the Association.

After conference with our Secretary, your committee recommends that the Association elect at this meeting an acting secretary. Doctor Henson states that while he has been able to attend to the affairs of the Association and those of the JOURNAL under his present assignment, he anticipates his military

his retiring from the active management of the Association and the JOURNAL. We believe, therefore, that it would be in the interests of the Association to elect an acting secretary and treasurer at this meeting, the elect taking over the office at such time as our present Secretary is unable to carry on the work, and to continue as acting secretary and treasurer during the term of the present Secretary or such portion of it as is consumed by the duration of the war.

WM. E. ROSS, M. D.

E. VAN HOOD, M. D.

### *Secretary's Report.*

At the last annual meeting of the Florida Medical Association, held at Atlantic Beach just a year ago, the profession of Florida, together with the profession all over the country, were in a state of tension with an anticipation of the part we were going to have to play to help win the war. At that time a large number of the members of this organization had already joined the Medical Reserve Corps of the United States Army, a certain number were already in the National Guard and others in the Naval Reserve Corps. At about that time the Surgeon General of the Army had stated that twenty thousand medical officers would be required to care for the sick and wounded of the army and it was anticipated that number would be put into the field. Florida's quota was placed at approximately two hundred. It is a pleasure and a joy for your Secretary to be able to report that this organization went over the top, and went in no uncertain manner. The profession of this State have sent two hundred and thirty officers into the Medical Reserve Corps, in addition to one in the Regular Army Medical Corps, nine into the National Guard of the United States and seven into the Navy. In the ratio of numbers to medical population Florida leads the South and is eleventh in the United States. That we are going to have a wonderful army, no one doubts; that it is going to be wonderfully well taken care of, is a foregone conclusion, and we may all be proud of the fact that The Florida Medical Association is bearing its full brunt.

Up to the time of writing this report twenty-one county organizations have filed their report for the



current year. There are at the present twenty-nine county organizations. With the authority of the Executive Committee I have advised all county organizations that one dollar and a half would be accepted in full lieu of annual dues of all members in the military or naval services. Most of the organizations have remitted on this basis for all absent members in the services; the remittance is made with the understanding that the amount so remitted will be credited to THE JOURNAL and that the Association will carry them as active members during the period of the war. It will be necessary for the House of Delegates to take action on this matter and your Secretary hopes and believes that the proposition will be accepted by an unanimous vote. It is also urged that favorable action be taken upon a recommendation the Executive Committee will make to assist in financing the Association for the period of the war. The war tax proposed may not be necessary every year, but the successful conduct of the affairs of the Association makes it necessary at least for the ensuing year. It will impose no hardship upon any individual, will insure the prosperity of this organization, and it is certain that at no other time during the history of organized medicine has there been a greater demand and necessity for complete organization.

GRAHAM E. HENSON, *Secretary*.

#### *Treasurer's Report—1918.*

##### RESOURCES.

Balance on hand last annual report.....	\$ 963.64
Back dues collected during year.....	69.00
Dues for ensuing year .....	689.50
	<u>\$1,722.14</u>

##### LIABILITIES.

Expense account (vouchers attached).....	\$1,476.45
Balance on hand .....	245.69
	<u>\$1,722.14</u>

GRAHAM E. HENSON, *Treasurer*.

#### *Financial Statement of The Journal of the Florida Medical Association—1918.*

##### RESOURCES.

Balance cash on hand last annual report...\$	17.19
Earnings from advertisements.....	1,035.39
Furniture .....	96.66
Cash Florida Medical Association.....	1,000.50
	<u>\$2,149.74</u>

##### DISBURSEMENTS.

Expenses (vouchers attached) .....	\$1,862.76
Commissions .....	128.42
Interest and Discount .....	35.17
	<u>\$2,026.35</u>

##### ASSETS.

Furniture .....	\$ 96.66
Cash on hand .....	26.73
	<u>\$2,149.74</u>

GRAHAM E. HENSON, *Secretary-Editor*.

The President appointed Doctors Wm. W. MacDonell and C. D. Christ a committee to audit the accounts of the Secretary-Editor and Treasurer.

The President announced that the House of Delegates would convene at 5 p. m.

The President called Doctor H. Mason Smith, Chairman of the Scientific Committee, to the chair.

The following papers were read and discussed:

"The Eye, from the Standpoint of the General Practitioner."—M. Price DeBoe, M. D., Cocoa.

"The Qualifications of an Examiner and the Examination that is to Correct Defects of Sight."—L. C. Ingram, M. D., DeLand.

"The Uvula." "What Is Nightmare, or *Pavor Nocturnus*?"—U. S. Bird, M. D., Tampa.

"Our Needs in Medical Legislation."—F. J. Walter, M. D., Daytona.

"Medical Jurisprudence."—Hon. Jas. F. Glenn, Tampa.

The Association adjourned until 2 p. m.

The Association was called to order by Doctor H. Mason Smith at 2 p. m. The President, Doctor Ralph Green, delivered his presidential address. He held his audience in intense interest, speaking extemporaneously of medico-military experiences gained while serving with Florida troops on the Mexican border and as Senior Surgeon with the 124th Infantry (Florida), with which organization he has been stationed for the past several months.

The following papers were read and discussed:

"Neglected Points in the Management of Communicable Diseases."—Wm. W. MacDonell, M. D., Jacksonville.

"Relation of the Medical Profession to the Public, and to Each Other."—R. R. Kime, M. D., Lakeland.

"Autogenous Vaccines."—Harold H. Fox, M. D., Miami.

"Cooperation."—B. L. Arms, M. D., Jacksonville.

The President, Doctor Ralph Green, called the House of Delegates to order at 5 p. m.

The Secretary, after explaining the finances of the Association, asked that the recommendation of the Executive Committee providing that a war tax of one dollar and fifty cents be levied against all members of the Association not in the military or naval services be adopted.

After discussion, all of which was in favor of the recommendation, it was moved by Doctor E. W. Warren and seconded that the recommendation of the Executive Committee be adopted. Carried unanimously.

Discussion arose concerning the necessity of raising funds for the purpose of properly drafting a bill governing the practice of medicine in the State to be presented to the next meeting of the legislature. Several plans were proposed. A motion by Doctor J. G. DuPuis, duly seconded, was carried providing that the Committee on Legislation and Public Policy be empowered to solicit funds from the members of the Association, provided that no one member be allowed to contribute more than ten dollars to this fund.

The Secretary read the following telegrams:

CAMP JOHNSTON, FLA., May 15, 1918.

Major Graham E. Henson, Secretary Florida Medical Association, Hillsboro Hotel, Tampa, Fla.:

Greetings. Am with you in spirit. Wishes for profitable meeting. ——— JOS. Y. PORTER.

BIRMINGHAM, ALA., May 15, 1918.

Florida State Medical Association, in Convention Assembled, Tampa, Fla.:

Greetings and all good wishes. Hope you are having most successful meeting.

SOUTHERN MEDICAL ASSOCIATION.

NEW YORK, May 14, 1918.

Secretary State Medical Association, Tampa, Fla.:

Regret I can not be present and wish you a most successful meeting. F. F. FERRIS,

Captain Medical Reserve Corps.

CAMP GRANT, ILL., May 15, 1918.

Florida Medical Association, Tampa, Fla.:

Wishing our Association continued success and the Allies' cause complete victory.

JOHN MACDIARMID.

The Secretary was directed to acknowledge these telegrams and to send appropriate replies.

The committee appointed by the President to audit the accounts of the Secretary-Editor and Treasurer submitted the following report:

*To President Ralph Green and Members of the Florida Medical Association:*

We, your Committee on Audit, have examined the accounts of the Secretary-Editor and the Treasurer and find them correct.

WM. W. MACDONELL, M. D.

C. D. CHRIST, M. D.

Doctor R. R. Kime offered the following resolution:

*Resolved*, That a committee of three or five be appointed to consider and study the subject of expert medical testimony especially in relation to mental conditions, also to formulate and secure such legislation as will be beneficial in relation to this subject. That the Superintendent of State Insane Asylum be chairman of said committee.

The adoption of the resolution, on motion duly seconded, was carried.

Upon motion of Doctor F. J. Walter, seconded by Doctor J. G. DuPuis, the following resolution was unanimously adopted:

WHEREAS, In the present crisis it becomes our duty to assist the Federal Government to conserve the health of civilians and soldiers alike; and,

WHEREAS, The Surgeon Generals of the Army, Navy and Public Health Service have asked special cooperation to prevent the spread of the venereal diseases; and

WHEREAS, Secondary cases of infection can be prevented only by knowledge of the source of infection,

*Be It Resolved*, That the members of the Florida State Medical Association go on record as not only agreeing to report all cases of notifiable disease, but to use their influence to compel all others to do likewise.

Upon motion, duly seconded, the House of Delegates adjourned.

The Association was called to order at 9 a. m. by the Chairman on Scientific Work, Doctor H. Mason Smith. The following papers were read and discussed:

"Treatment of Syphilis of the Central Nervous System."—H. Mason Smith, M. D., Chattanooga.

"Atypical Syphilides and a Consideration of the Treatment of Syphilis."—J. Lee Kirby-Smith, M. D., Jacksonville.

"A Plain Talk on Tuberculosis."—J. M. Masters, M. D., Port Orange.

"Report of a Duodenal Tumor Treated With Ipecac."—Mary Freeman, M. D., Perrine.

"Malaria and a Multi-Millionaire; an Interesting Incident of the Spanish-American War, as Told by a Veteran."—E. Van Hood, M. D., Ocala.

"Treatment of Pneumonia." — Chas. Robert Oglesby, M. D., Lakeland.

"Colitis."—R. E. Wilhoyte, M. D., Lake Wales.

"Acute Intestinal Obstruction Relieved With Pituitary Extract."—R. A. Ely, M. D., Tampa.

"Laboratory Work in General Practice." — Ben V. Caffee, M. D., Winter Haven.

The President assumed the chair at 12 o'clock and announced that the election of officers for the ensuing year was in order.

The election resulted in the following officers being chosen to conduct the affairs of the Association for the ensuing year:

Doctor F. J. Walter, Daytona, President.

Doctor W. P. Adamson, Tampa, First Vice-President.

Doctor H. Mason Smith, Chattahoochee, Second Vice-President.

Doctor C. V. Caffee, Winter Haven, Third Vice-President.

Doctor E. W. Warren, Palatka, Acting Secretary.

Doctor John S. Helms, Tampa, Delegate to the American Medical Association (two years).

Doctor L. C. Ingram, Alternate Delegate to the American Medical Association (two years).

Miami was chosen as the place for the holding of the next meeting and the Executive Committee directed to select a date for the meeting.

Upon motion, duly seconded, the Association adjourned at 1 p. m.

The Association was called to order by Doctor H. Mason Smith, at 2 p. m., the following papers being read and discussed:

"First Aid Surgery."—Oliver J. Miller, M. D., Jacksonville.

"Caudal Anæsthesia."—G. H. Hodgson, M. D., Tampa.

"Dakin Solution in Compound Exposed Fracture of the Lower End of the Humerus." —G. C. Bottari, M. D., Tampa.

"An Operation of the Lower Ureter, for Stone."—J. C. Vinson, M. D., Tampa.

"Abscess of Liver."—S. Stringer, M. D., Tampa.

"Secondary Fibro Sarcome of the Clitoris." G. H. Edwards, M. D., Orlando.

A resolution, offered by Doctor J. G. Dupuis, thanking the local committee for the well-arranged meetings, entertainment and cordial good will was adopted by a standing vote.

Upon motion, duly seconded, the Association at 5 p. m. adjourned *sine die*.

## ORIGINAL ARTICLES

### OUR NEEDS IN MEDICAL LEGISLATION.\*

FREDERICK J. WALTER, M. D.,  
Daytona, Fla.

Our needs in medical legislation are just what any State needs to protect the people

\*Read before the forty-fifth annual meeting of the Florida Medical Association, at Tampa, May 15-16, 1918.

from uneducated imposters who desire to make money at the expense of the people. Therefore it is in reality the people's fight and not the fight of any physician or any set of physicians to obtain this protection for the people. However, it is the physician who is in a position to judge the injury done by men who are taking advantage of the public. It is the physician who knows the man capable



of making a diagnosis, and we may as well state here that the man capable of making a diagnosis is an educated man.

There are no hidden secrets in diagnosis, for the goal is reached only after thorough scientific study. Therefore if a man is a diagnostician he usually knows his treatment, and it is practically safe to trust him with treatment. We should, therefore, have a standard of education and of preliminary education. Usually an educated man will not be a freak, and usually the educated man has no trouble producing his credentials. The educated man is in other words a safe man to trust in the treatment of disease. A man who takes the trouble to educate himself is usually conscientious, and such a man is a safe man. It is the uneducated man with low standards and the believer in short cuts that seeks to practice some freak system without credentials, and our fights in the legislature have always been against the men who object to tests of knowledge. In nearly every State the people have put it up to the qualified physicians of the State, who know the pitfalls, to get a medical practice act passed by the legislature. In Florida there has always been an implication by some legislators that the physicians were after some special privilege or monopoly.

It is the writer's conviction that a new bill must not come from this society directly. It is our business to educate the people and let them insist upon protective legislation. The medical societies throughout the State will have to do a little work and furnish some speakers, and through the woman's clubs and other organizations show exactly what is needed. The people must know that Florida is behind other States in protective medical legislation. The people must be told the danger of having an unqualified man treat cancer by rubbing or open an abdominal abscess into the peritoneal cavity by the same means. The people must be told how fake diplomas and fake colleges have allowed men to practice upon their families under the cloak of the present law. Between now and

the next meeting of the legislature there is time to do this provided we work for it and are really in earnest. We may dislike the idea of introducing so many bills, but there is really no good reason why we should not have it done by the people themselves who will insist upon action if properly advised of the need of such legislation. The people must be told of the danger of many standards and back-door routes and multiple boards of examination. If possible it would not be a bad idea to put the whole situation up to the department of public instruction with a few medical advisers. The interests of any sect in medicine is subordinate to the health of the people. The quack does no harm to the medical profession directly; he rather makes business for the honest man. The quack, however, does take many lives and much money from the public. Our present law is very defective and we have no power to convict a man of gross criminal acts. The men asking for special privileges are men from other States often coming for a short time, to make money, and have not the spirit possessed by the true physician.

To be really protective a law must, in addition to having a fair standard of preliminary qualifications, have a clear-cut definition of the term "Practice of Medicine." The term should cover healing in all its forms; for if this is not done many fads will crop up with the claim that they are not practicing medicine. In addition to this there must be power given a board to refuse and revoke a license, which is not given at all in our present law. The fees for the examinations should pay the expenses of the board. A bill should be made just as short as possible, though too much arbitrary power must not be left to the board. In the matter of reciprocity, Florida being a tourist State, we can hardly afford to reciprocate licenses unless the candidate has a certificate from the National Board of Medical Examiners. Such a certificate is most certainly the highest endorsement it is possible to give a medical man in America, and the number of such applicants would not

likely exceed one a year for the next quarter of a century.

In addition to educating sentiment in the State, we should send a live attorney to Tallahassee to remain during the entire session of the legislature to weather the bill and explain to the legislature that the bill is *there to pass as the wish of the people*. The bill should not be introduced by a physician in the house or senate.

Now is the time for each medical society in the State to select a committee known as a committee to direct public sentiment. This committee should be made up of the strongest men in the society. They should meet and appoint public speakers to go over the situation the coming season with the various clubs, forums and civic societies of their respective counties. Material should be supplied these speakers to cover the ground thoroughly, and the thought should be left that the fight is for the protection of the public, that no sect has interests higher than the health of the people, that Florida at present is unprotected against many of the worst forms of medical imposters.

It should be the duty of the present House of Delegates to give the President of this society the power to select these committees and to arrange with the Committee on Legislation to keep an attorney in Tallahassee next spring. The President and the Legislative Committee should confer on the matter of the kind of a law and keep the members constantly advised on what to do and of the progress being made in detail through the JOURNAL. Each member of the society should consider the matter a vital one and personally devise means best fitted to arouse sentiment in his section of the State. Records should be kept of cases where unregistered physicians, advertising charlatans and mountebank doctors have taken people's money deceitfully; also those cases made worse or neglected by improper treatment. This material should be on record for use in arousing sentiment for clean medicine.

An independent act, such as the Preliminary Educational Act of the State of Tennessee, might best pass the legislature along with other educational matters such as an act requiring *conditions* being put upon colleges desiring to confer degrees in this State, which at present is entirely neglected. The preliminary educational requirements before an examination can be given, has so far worked well in Tennessee. The Secretary of the Tennessee Board writes me that it is "very satisfactory" and "I could not suggest any changes" to better it. Some day a college giving degrees with very little study will apply for a charter in this State and as it is the faculty is required to have no special qualifications to issue degrees. At present it ought not to be difficult to pass such a bill except that there is always so much legislation to be acted upon at each session of the legislature it is apt to be thrown out unless someone is right there to see to it. If only the act requiring a good preliminary education could be passed it would start us a long way on our route.

However, it would be best to get a general bill through. If found again impossible to do, we should exert our energies towards getting an act passed requiring certain preliminary qualifications before a candidate can come before the board. To sum the matter up, we should be *up with other States in the matter of medical legislation and education in Florida*. Medical acts in most of the States are not panaceas. They are usually the best that can be done. There are many unqualified men in our ranks and it will take years before the real good effect of the act becomes apparent. After an act becomes a law it requires constant watching to keep it on the books and harmful amendments from being added. It is not the nature of a 100-per-cent American to give up, so let us get together on this question and give the people *just and real medical protection in the State of Florida, and make the legislature feel that the people want that protection*.

Points for members to remember when speaking to their representatives in the legislature :

Physicians have no selfish motives in asking for better medical laws to protect the lives of the people of Florida.

In asking for a single standard of education for men who diagnose disease, regardless of treatment, we are asking for what should appeal to anyone.

Our present law is very defective and has no power to convict a man guilty of gross criminal acts.

We ask to avoid multiple routes to men who heal.

That the men asking for special privileges are men from other States coming here for a short time to make money and have not the spirit possessed by the true physician.

*Press the matter of single standards and the avoidance of back-door routes with low standards.*

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## THE EYE FROM THE STANDPOINT OF THE GENERAL PRACTI- TIONER.\*

M. PRICE DEBOE, M. D.,

Cocoa, Fla.

A full knowledge of the eye with its relations and sub-relations would embrace all knowledge. Just so with any material substance, but the eye has so many direct relations and there are so many ways to approach this vast field for research and investigation that we as medical men can not afford to overlook the gold mine of signs and symptoms which it furnishes as a guide in the diagnosis of diseased conditions with which it is directly connected.

From a standpoint of diagnosis, this is true because of the fact that there are no tissues in the body so quickly and noticeably changed by the process of disease as the tissues of the eye. In the bloodless parts, as

the cornea and lens, and the semi-bloodless tissue, as the retina, there is not the immunity to injurious influences as there are in other parts of the body. Therefore we have, in these tissues, diseased conditions demonstrable long before they make their appearance at their real focus of origin or give symptoms in any other part of the body.

Until the day of Helmholtz this great physiologic and pathologic field of research lay unexplored. But since his discovery of the ophthalmoscope this dark cavern has been well explored and many hidden mysteries have been brought to light. Now with the modern ophthalmoscope all the interior of the eye can be readily seen under the direct vision. And there is no place in the body where the circulatory and nervous systems are laid bare for study as in the retina.

As there is no sharp borderline between the two great specialties in medicine, there necessarily come cases which lie on both sides. These cases are divided into two classes: those which belong to the oculist but whose symptoms are referred to some other part of the body and those which belong to the general practitioner but whose symptoms are referred to the eye.

In the first class we deal with symptoms, one of the most prominent of which is pain. Only the anterior part of the eye is supplied with sensory nerves. The retina, choroid and optic nerve are not sensitive to pain, but when there is inflammation of these parts the pain arises from the optic nerve sheath. Pain is usually associated with photophobia and lacrymation, all three of these symptoms being due to irritation of the fifth cranial nerve. Pain in the cornea or sclera is nearly always direct, but pain in the uveal tract is often referred to the forehead, temporals, ears or teeth of the upper jaw. This is called a ciliary pain. In iritis the pain comes on by spells, often coming on at a certain hour in the evening or night and very often marked relief is gotten from a dose of quinine, which fact is liable to be misleading in that malaria

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\*Read before the forty-fifth annual meeting of the Florida Medical Association, at Tampa, May 15-16, 1918.



is suspected, when in reality there is not a trace of this disease. The conjunctivitis, accompanying iritis, is by no means an index as to the severity of the condition. The main signs to look for in this condition are the circumcorneal injection which consists in a violet halo around the cornea which does not move when the cornea is moved over the injected part, and an irregularity or fixed conditions of the pupils. When there is swelling of the lid in this symptom group it means irido-cyclitis.

This ciliary pain in some cases is present in glaucoma, but in glaucoma instead of contracted pupils you have dilated pupils, a shallow anterior chamber, cloudiness of the cornea, cupping of the disc and increased tension.

The pain in corneal ulcers is direct, but as there is a constant tendency to an osmotic action in the tissues of the eye, toxins from the infection in the cornea pass back and set up a secondary iritis. Therefore pains referred to different parts of the head during an attack of corneal ulcers should always be looked upon as serious.

Headache is another symptom which is common to certain eye troubles. Hypermetropia and astigmatism cause headache after using the eyes for near-work. Muscle errors cause headache after a trip or a long drive which disappears as soon as the patient gets quiet and gets a nap of sleep. People with muscle errors generally complain of a drawing pain in their eyes after reading. These patients also complain of the lines running together when reading.

Neurasthenics have headache after reading, but there are other signs to guide the diagnostician in these cases.

Patients are often sent to the oculist on account of vertigo. Vertigo is not to be confounded with the ordinary description of swimming which the average patient describes. Most patients do not describe this symptom very accurately, as it is a very hard symptom to describe. As there is no external evidence of its existence, it is necessary for

us to get as accurate a statement from the patient as possible. The leading questions will give us a clue to the cause of the vertigo, which has for the most part to be determined by the statements as to the time of the attacks, the conditions under which they come, and the length of time they last. Optical vertigo is usually diagnosed by exclusion.

The false localization in which the patient sees an object in one place when it is at another or the false movements of objects are often seen in paralysis or paresis of the extraocular muscles. A paresis of the trochlear causes a vertigo when the patient looks down.

A peculiar thing about these paralyses, and an important thing from a standpoint of diagnosis, is that the paralysis of central origin does not often cause vertigo at all, while that due to a peripheral lesion causes vertigo in a distressing form.

Where vertigo is associated with other symptoms, headache, vomiting and choked disc, it means brain tumor or some condition causing intracranial pressure.

This is merely a hasty view of some of the eye conditions indicated by general symptoms which are seen by the general man. Now there are a number of conditions which have their lesion in some other part of the body, but whose signs or symptoms are in the eye.

Locomotor ataxia is one of the most prominent of the last group. As there are cases of locomotor ataxia which have never given trouble we are liable to overlook this dreaded disease if we ignore the eye signs. Very often the first symptom is iridoplegia with the pupils contracted. Now, parenthetically, we will review briefly the cause of this and we will readily see how it is. Most cases of locomotor ataxia have their lesions first to appear in the column of Lissauer and the posterior roots. Later on sclerosis takes place in the column of Burdach. Then as it passes up the cord it involves the column of Goll and finally the fibers from the posterior roots leading to the column of Clark, but not the cells in the column of Clark. This is the usual pathology, but some observers think that the first lesion

in most cases is in the spinal ganglia. This certainly must be true, as the dilator center for the pupil is in these ganglia and any destructive lesion in the cord causes a contraction of the pupils and any irritative lesion causes the pupils to dilate. (In the brain the opposite is true: a destructive lesion causes a dilatation of the pupils and an irritative contraction.)

Argyll Robertson pupils are those which react to accommodation, but do not react to light. This is the most common eye symptom in tabes. This symptom is seen in several other nervous diseases, especially in general paresis.

Optic nerve atrophy is another symptom of tabes. The characteristics of this atrophy are, the optic disc is white or grayish white, the margins are clearly defined, the blood vessels are normal or slightly contracted, the physiologic cup is normal and there is a concentric contraction of the field of vision with sectors of blindness. The one peculiar thing about locomotor ataxia with optic atrophy is that the ataxic symptoms seldom come on. This is probably due to the fact that the patient is unconsciously reeducated as he gradually loses his vision.

In multiple sclerosis there are eye symptoms in about one-half of the cases. This consists in a semioptic atrophy, the temporal half of the optic disc being white. As the temporal half is normally whiter than the nasal, it is necessary to take the visual field in which a central scotoma will be found, first for red and green, later for white. Sometimes these signs develop years before the general symptoms make their appearance.

Nephritis, in some cases, gives evidence first of its existence in the eye. Cases are often sent to the oculist on account of failing sight, when upon examination a typical case of albuminuric retinitis is found. This type of retinitis is usually marked by the presence of a stellate deposit in the region of the macula. There are also white patches often seen around the disc. Hemorrhages in the retina make the evidence strong for chronic

interstitial nephritis. The stellate figure is not always pathognomonic of nephritis, as it is seen in young people occasionally and seemingly without any discoverable cause. It may also be caused by rheumatism, diabetes or brain tumor. There is often a papulitis accompanying this condition resembling choked disc.

Eye symptoms in syphilis are legion. And if syphilis could be eradicated, it would also mean the eradication of 75 per cent of the inflammatory diseases of the eye. In the second stage of syphilis iritis is the most common eye condition, while conversely secondary syphilis is the most common cause of iritis; about two-thirds of all cases of iritis are due to this disease.

Syphilitic iritis is characterized by the formation of yellowish red nodules on the iris. These nodules are from the size of a pinhead to the size of a pea and are situated either upon the ciliary or pupillary margin of the iris, never at an intermediate point. These nodules are by no means constant in syphilitic iritis, but when they do appear they are practically positive signs of syphilis.

In syphilis of the nervous system there is often a gummatous lesion in the optic nerve causing some form of hemianopsia, the type of hemianopsia being determined by the location in the nerve or optic tract of the lesion.

We also see optic neuritis in syphilis of the nervous system sometimes. This is to be diagnosed from choked disc by its sudden onset as differing from cerebral tumor.

Exophthalmic goitre is a disease whose diagnosis can almost always be made by the eye signs. The classical signs are: Exophthalmos, Dalrymple's sign, Von Graeff's sign, Stellwag's symptom, and Moebius' symptom. Dalrymple's sign is a condition in which the upper lid stays very wide open, giving the patient a look of excitement or fear. Von Graeff's is due to the same cause. When the patient looks down, the lid does not follow the ball, leaving a part of the sclera exposed above the cornea. In Stellwag's symptom the patient seldom winks, therefore the

cornea becomes dry. Moebius' symptom is the lack of power to converge.

In pellagra there are a number of eye symptoms. Whether they are coincidental or not is not definitely known. There is a condition of thickening of the retina giving a peculiar yellow reflex. It is the consensus of opinion that the pupils are dilated in this disease. It would be interesting to hear the experience of others in regard to the eye symptoms in this disease, as I personally have not had very much experience with it.

In this paper I have not tried to cover even superficially all the borderline cases or the cases in which the general man and the oculist are equally interested. I have merely attempted to show by some of the most striking examples the importance of a more careful study, on the part of the general man, of borderline ophthalmology.

This organ of sight of which the poets have sung for all ages and after which artists have modeled for time immemorial is more wonderful from a scientific point of view than from a cosmetic or artistic. This organ for whose benefit the blazonry of bloom of the plant world and the pleasing decorations of the animal kingdom are created, and to satisfy which the rude outlines of all nature are smoothed out in exquisite grandeur; this great recording screen which photographs the details of our environments, because of its high specialization and delicate structure, in the great balance sheet of nature pays the debt of deterioration for the less sensitive tissues.

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#### AUTOGENOUS VACCINES IN THE TREATMENT OF DISEASES OF THE EAR, NOSE AND THROAT.\*

HAROLD H. FOX, M. D.,  
Miami, Fla.

Since Pasteur succeeded in protecting sheep against anthrax, by the inoculation of

an attenuated culture of the anthrax bacillus, the treatment of diseases of the human system by the use of autogenous vaccines has been recognized as an important therapeutic measure. In spite of the fact that numerous cases so treated have been favorably reported, many physicians still hesitate to use this form of treatment except in their most obstinate cases, and then only when all other means at their disposal have failed to effect a cure. This reluctance on the part of certain physicians to adopt autogenous vaccines to a place in their armamentarium, for the combating of disease, possibly arises from ignorance of the principles of modern bacteriology, or possibly from the fact that the physicians having tried stock vaccines, and having found them of little or no value, have condemned all vaccines as worthless, both stock and autogenous.

Due to the influence of Wright, and his statements in regard to the so-called "negative phase," it was at one time supposed that the administration of an autogenous vaccine was fraught with danger to the patient, and that in order to secure favorable results, the reaction and the dose must be checked by means of the opsonic index.

With a properly prepared vaccine, and in selected cases, autogenous vaccines are perfectly innocuous. As regards the opsonic index, this measure is so time-consuming and so variable, and so often incomplete understanding of the phagocytic reaction may cause misleading deductions, that the trend of modern opinion is to relegate the opsonic index to the realm of experimental investigations.

Realizing the vast field open to vaccine therapy, and the consequent possibility of immense profits, certain semi-proprietary houses have flooded the country with quasi-scientific preparations, known as bacterins, phalycogens, polyvalent vaccines, mixed vaccines, etc., all to a greater or less degree forms of the stock vaccine.

To scientific workers along biological lines, it is well known that each species of

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\*Read before the forty-fifth annual meeting of the Florida Medical Association, at Tampa, May 15-16, 1918.



bacteria is made up of many sub-groups, in themselves composed of many individual strains, all having more or less difference in their immunological reactions. It may be readily understood why in the majority of cases such poor results are attained following the administration of stock vaccines, even though, which is seldom the case, the choice of this vaccine is based on correct bacteriological lesions. It is rare that the practicing physicians will give more than one box containing usually four ampoules of the stock vaccine. Such treatment within the dosage and time prescribed by the manufacturers, scarcely gives opportunity for protective antibody formation, even though the physician be fortunate enough to secure a species of vaccine containing a strain of bacteria approximately correct. I believe that the favorable transient results, sometimes noted in the first week of such treatment, are due to either protein sensitization, or to non-specific stimulation of polymorphynuclear leucocyte production. These reactions are noted as well with the use of autogenous vaccines, and in addition there is the specific antibody response.

This antibody production is specific, since the bacteria stimulating such productions, having been taken from the diseased area, are homogenous in strain group and species with the bacteria still residing in the tissues and producing poisons, whether endogenous or exogenous.

It was my privilege to report in the *Journal of the American Medical Association*, in the issue of June 24, 1916, a series of one hundred unselected cases of acne vulgaris and furunculosis, occurring among the students of Cornell University, and treated with stock vaccines. The results on the whole were very discouraging. I have now to report a series of twenty ear, nose and throat cases referred to me by Dr. B. F. Hodsdon, of Miami, Fla., for cultures and autogenous vaccines. The results we have attained have been remarkably good, considering the fact that many of these cases were

of such a chronic nature as to practically exhaust the patience of the medical practitioner. (See pages 362 and 363 for series of cases reported.)

In this series of cases the youngest to receive the vaccine was ten years of age, and the oldest seventy-six. Age seemed to have no influence on the reactions. The initial dosage given ranged from approximately two hundred fifty million with *Streptococcus* cultures, to a billion in those showing organisms of the *Staphylococcus* group, three to four days being the usual period between doses. Better results were secured by pushing the dosage sufficiently each time to produce a moderate constitutional reaction. Dr. Hodsdon secured this increase in dosage both by gradually increasing the amount of vaccine given, and by cutting down the intervals between doses.

The results attained in these cases have far exceeded expectations and they have shown us that autogenous vaccines have a very considerable value in the treatment of both acute and chronic cases.

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#### THE QUALIFICATIONS OF AN EXAMINER AND THE EXAMINATION TO CORRECT DEFECTS OF SIGHT.\*

L. C. INGRAM, M. D.,  
DeLand, Fla.

There is some confusion with the laity, and with some physicians as well, over a standard of qualification required to prepare an individual to properly examine and prescribe for defects of sight. It is not the purpose in this paper to discuss only the symptom which arises from a refraction or muscle error, but with a broader view. Think of the patients who have a diminished or loss of vision! A disturbed function of the eye oftentimes necessitates a very careful study of physical and pathological changes in other

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\*Read before the forty-fifth annual meeting of the Florida Medical Association, at Tampa, May 15-16, 1918.

NAME.	No.	PATHOLOGICAL CONDITION.	SYMPTOMS.	CULTURE.	RESULTS.
<i>Mr. B.</i>	1.	Chronic otitis media. Twelve years' duration.	Continuous purulent discharge not relieved by medication. Joint and muscular pains. Headaches. Considerable bilateral deafness.	Culture from ear showed Staphylococcus pyogenes aureus, Staphylococcus pyogenes albus.	Considerable local and general reaction after each inoculation, but did not have to give up work. Aural discharge ceased after fourth treatment. Concealed otitis cleared up. Rheumatic pains ceased. No headaches. No further complaint from patient.
<i>Mr. S.</i>	2.	Chronic pharyngitis. Twenty years' duration. Sputum negative for bacillus of tuberculosis. One Wassermann positive, one negative and one anticomplementary from different laboratories.	Pharyngeal wall very sensitive. Frequent coughing to expel mucus formed on pharyngeal walls. Climatic change from Middle West to seashore gave no relief.	Culture: Micrococcus catarrhalis.	Slight local and general reaction. Mucus discharge and cough practically cleared up at end of ten days. Ascribes benefit to vaccine. No further complaint.
<i>Mr. B.</i>	3.	Chronic pharyngitis, involving upper larynx. Several years' duration. Recent acne rosacea with involvement of upper lip. Sputum negative for bacillus of tuberculosis. Wassermann negative.	Cough with slight expectoration. Pains in joints. Sero-purulent discharge from nose. Nose and upper lip swollen. Patient despondent and unable to sleep at night except for short periods.	Culture from nasal fossæ: Streptococcus pyogenes, Staphylococcus pyogenes aureus.	Marked local and general reactions. Nose and upper lip rapidly improved. Nasal discharge ceased. Looks and feels better. Sleeps better. Little improvement in laryngeal condition. Patient left city before completing course of treatment.
<i>Miss R.</i>	4.	Unilateral frontal sinusitis. Several months' duration.	Facial neuralgia. Abundant purulent discharge from nose. Feels sick.	Culture from nasal fossæ: Micrococcus catarrhalis, Streptococcus pyogenes, Staphylococcus pyogenes aureus.	Rapid improvement and clinical cure. Pains in head ceased entirely. No discharge. Patient states she "feels fine."
<i>Mrs. D.</i>	5.	Chronic naso-pharyngitis. Four years' duration. Present attack nature of acute exacerbation.	Muco-purulent nasal discharge. Headaches. Marked inflammation of mucous membranes of nose and throat. Patient nervous and irritable.	Culture from nasal fossæ: Staphylococcus pyogenes aureus, Bacillus mucosus capsulatus.	Nasal discharge ceased. No headaches after first week of treatment. Nervousness and irritability cleared up. Case clinically cured.
<i>Capt. F.</i>	6.	Chronic otitis media. Furunculosis of external auditory canal. Duration, twelve years. Wassermann 2+.	Pruritis of external auditory canal. Slight semi-purulent discharge. Insomnia. Tinnitus aurum. Partial deafness. Patient very nervous.	Culture from middle ear: Bacillus pyocyaneus.	Treatment continued several weeks before improvement, then tinnitus and pruritis and discharge ceased. Insomnia less. Nervousness less. Hearing improved. Looks and feels better.
<i>Mrs. H.</i>	7.	Chronic pharyngitis and laryngitis. Tonsillitis. Several years' duration. Sputum negative for T. B.	Headaches, "Rheumatic" pains. Sore throat. Digestive disturbances.	Culture from nasal fossæ: Micrococcus catarrhalis, Staphylococcus pyogenes aureus.	Tonsillitis cured. Cough less. Headaches ceased. Patient thinks vaccine has improved her general physical condition.
<i>Mr. B.</i>	8.	Chronic tonsillitis. Seven years' duration. Tonsils show large crypts.	Frequent rheumatic attacks with swelling of joints. Frequent headaches. Digestive disturbances. Throat very sore.	Culture from tonsils: Streptococcus pyogenes hæmolyticus.	Inflammation of throat cleared up. Rheumatic pains ceased. Tonsils removed. Very little hemorrhage. In bed but two days. Vaccine continued.
<i>Mr. S.</i>	9.	Chronic frontal sinusitis. Ethmoiditis and tonsillitis. Hyperplasia of nasal mucous membrane.	Obstruction of nose. Unable to sleep lying down. Mouth breather. Severe headaches. No improvement from climatic change. Slightly improved by local operations.	Culture from nasal fossæ: Streptococcus pyogenes longus.	Marked local and general reactions. Striking improvement. Patient able to sleep on back with mouth closed. Sinus discharges ceased. Patient much improved after two weeks' treatment.

<i>Mr. W.</i> 10. Chronic tonsillitis and sphenoiditis. Sputum negative for T. B.	Annoying muco-purulent discharge of throat. Headaches. Sore throat. Feels generally unfit.	Culture from throat: Staphylococcus pyogenes albus, Staphylococcus pyogenes aureus.	Slight local reaction only. Throat improved. Feels somewhat better physically. A second culture has been made in this case.
<i>Mr. E.</i> 11. Acute attack exacerbating chronic tonsillitis. Severe inflammation of tonsils and adenoid.	Sore throat. Loss in weight. Muscular and joint pains. Dysphagia.	Culture from tonsils: Streptococcus pyogenes hemolyticus.	Marked local and general reactions. Inflammation of throat subsided. Pains ceased. Tonsils removed. Rapid convalescence.
<i>Mr. K.</i> 12. Frequent recurring tonsillitis. Tonsils hypertrophied and cryptic. Purulent material in crypts.	Sore throat. Digestive disturbances. "Rheumatic" pains. Tired feeling. Foul odor to breath.	Culture from tonsils: Streptococcus pyogenes, Staphylococcus pyogenes albus.	Marked local and general reactions. After four treatments inflammation of throat subsided. Tonsils removed only local anæsthetic. No untoward symptoms.
<i>Lt. H.</i> 13. Chronic tonsillitis. Present acute attack.	Sore throat. Catches cold easily. Muscular and joint pains.	Culture from tonsils: Streptococcus pyogenes.	Slight general and marked general reaction. Decided against tonsilectomy. Vaccine continued.
<i>Mr. H.</i> 14. Chronic tonsillitis. Chronic nasal pharyngitis. Tonsils hypertrophied with deep crypts.	Sore throat. Frequent colds. Fetid breath. Digestive disturbances.	Culture from tonsils: Streptococcus pyogenes longus.	Moderate reactions. Tonsilectomy performed. Rapid convalescence. Vaccine continued.
<i>Mrs. E.</i> 15. Super maxillary sinusitis. Chronic tonsillitis. Five years' duration.	General septic condition. Periodic discharge of purulent masses from super-maxillary sinus. Angina. Difficult nasal respiration. Anorexia. Headache. Partial deafness. Rheumatic pains.	Culture from sinus discharge: Micrococcus catarrhalis and staphylococcus pyogenes albus.	Slight local reaction. Rapid improvement. Patient stated she "never felt better in her life."
<i>Mr. A.</i> 16. Chronic ethmoiditis and nasal polyps. Recent anterior ethmoidectomy and polyps removed.		Culture from nasal fossæ: Streptococcus pyogenes aureus, Friedlander's Bacillus.	Increasing local and general reactions. Concealed cystitis cured. Appetite improved. Nasal discharge lessened. Better mental and physical tone.
<i>Mr. W.</i> 17. Chronic tonsillitis. Three years' duration. Severe facial acne vulgaris for same period.	Sore throat. Dysphagia. Feeling of apathy. Frequent colds.	Culture from tonsils showed Streptococcus pyogenes, Staphylococcus pyogenes aureus.	Moderate reactions. Resistance to cold increased. Acne disappeared. Tonsillitis subsided. Patient considers himself cured.
<i>Mr. D.</i> 18. Chronic pharyngitis. Twenty years' duration. Sputum negative for T. B.	Pharynx hyper-sensitive. Slight cough. Constant feeling of discomfort in throat.	Culture from pharynx: Micrococcus catarrhalis.	Very slight local and general reactions. Cough diminished. Mucus in throat lessened. Improvement apparent to patient.
<i>Mr. P.</i> 19. Chronic tonsillitis. Markedly hypertrophied tonsils with deep crypts. Stomatitis and laryngitis present. Sputum negative for T. B.	Dysphagia. Anorexia. Insomnia. Fetid breath. Depressed. Headaches. Frequent rise in temperature. Sore mouth.	Culture from tonsils: Streptococcus pyogenes hemolyticus.	Initial doses very small. Moderate local and general reaction. All pathological conditions exhibited change for the better. Tonsils removed. Slight hemorrhage and rapid convalescence.
<i>Master H.</i> 20. Chronic tonsillitis. Physical development retarded. Mouth breather. Condition ascribed to uncinariasis. Feces negative for animal parasites or ova. Sputum negative for T. B.	Mental torpor of moderate degree. Frequent attacks of angina. Nervousness and irritability marked. Foul odor to breath.	Culture from throat: Streptococcus pyogenes longus, Staphylococcus pyogenes aureus.	Reactions slight. Parents noticed improvement in child's mental and physical condition. Tonsillitis subsided, and tonsils diminished in size. Tonsilectomy performed. No untoward circumstances. Vaccine continued.



organs even remote from the apparent trouble, in order to arrive at a fair degree of accuracy in diagnosis and be in a position to apply the proper remedy. Disturbed or poor vision may be due to an optical defect or the result of a pathological process in some structure of the eye itself or secondary to a diseased process in some other organ of the body. This should convince us that no one who does not understand human anatomy and human ailments in a broad sense and the diseases of the eye minutely should be trusted to examine so delicate and important an organ as that of sight.

Very much of the present condition of affairs has been brought about by misdirected legislation. There was an honest intention in framing most of the laws to protect the public against unscrupulous and uneducated physicians and to elevate the standard of physicians. Very much has been accomplished as medical preparation has been advanced and the public benefited. We know, however, that there is a constant effort by the unscrupulous to get around the intent of the law as far as their business is concerned and defeat the best aims of legislation. They band themselves into societies and through the invention of some "ism" they seek through legislation to become recognized as physicians. These near-physicians, with the assumed dignity, fleece many of the innocent afflicted at a great cost to public health. Instead of medicine and surgery and its perfected branches covering the only profession embodying every known method in the diagnosis and treatment of human ailments, these little "isms," as osteopathy, chiropractic, optometry, etc., have legalized these individuals to become full-fledged physicians.

I want to call your attention to the Optometry Act, as it licenses opticians and jewelers to examine and prescribe for refractive errors of the eye. Too many of them misconstrue the intent of the act and assume themselves capable of diagnosing and treating eye diseases. In their training, opticians

are made competent lens-grinders and framemakers and fitters, but not physicians. They are not drilled in human anatomy and pathology. They can not diagnose and treat diseases by their training. They can test the vision subjectively, and when the patient claims to see better with a certain strength of glass they can prepare the glass for them to use. Their stock in trade is glasses, and every optically defective eye and every diseased eye and symptom complex must have a pair of glasses. They wend their way into every nook and corner of the cities, every hamlet and countryside, to peddle their ware and treat the eyes. Sometimes this happens to be an unfortunate thing for the patient who has a disease undiagnosed and untreated, and allowed to progress beyond the chance of recovery. Thus we must see that it is not a question of proficiency in examining for refraction errors, but a proficiency that makes the examiner competent to diagnose other troubles that simulate refraction symptoms. To do this there must be a rounded knowledge in medicine. A court of law would not permit a man to be entered at the bar and practice law if he had studied and made himself proficient in one branch of law; for instance contracts. To be qualified as an attorney he must first be educated in all branches of law, and then he may specialize and practice one branch if he choose.

In order to be licensed to practice regular medicine in this State at present the applicant must be twenty-one years old, and be a graduate of at least a class B medical school and pass a satisfactory examination before the State Examining Board.

A license for optometry in the State requires that the applicant be at least twenty-one years of age, have two years of high school and two years of study under an optometrist or a graduate of a school of optometry and pass an examination on the fitting of glasses.

Twenty-seven States at present have similar optometry laws, and with the requirement for graduates by so many States there

is no true school of optometry or university ranking in the country. Columbia started such a school with a two-year course, but recognized the viciousness of the eye examination without a medical training and did not grant the degree. Outside of the opticians in the cities who form classes and teach the fitting of glasses, the so-called optometry schools are side issues of patent medicine vending houses who educate opticians to find agents for their medicines. Many of these men have not been content with the title of optometrist given them by the school or examining board, but give to themselves the title of doctor or eyesight specialist, etc. They want the public to believe they are eye specialists and physicians, and my experience with some of them is that they gain this point. Patients applying to me for aid spoke of Doctor so and so, an optician, treating their eyes.

The business of the optician is to grind and prepare lenses according to a physician's prescription. The law, however, gives to the optician the right to prescribe for conditions which can be recognized and treated only after years of study and training in medicine, and has legalized the doing of an irreparable injury. Without even the smattering of medical knowledge, he can prescribe for the eyes of a man who is suffering from Bright's disease, from rheumatic or luetic troubles, which diseases and others may affect directly or indirectly the eyesight. He may treat all without any knowledge of these diseases or of the general principles of anatomy, physiology, or pathology. He has no more business to prescribe for diseases of the eye or attempt to treat abnormal conditions of the eye than has a shoemaker or glovemaker to treat diseases of the feet or hands. The average druggist is far more competent to prescribe digitalis than the optician is to prescribe glasses, yet few people suffering from some heart or kidney disease would feel satisfied to employ the druggist to prescribe for these troubles.

When we see a case of Bright's disease far

advanced, treated for his headaches by an optician with a glass for months, and when we examine the fundis and find damage done to the vessels and exudates around the macula from arterial tension, and we can see that the prognosis is bad; when we see a sight lost absolutely in a high myope from retinal detachment after a strong minus glass had been prescribed without an understanding of the case in hand and proper instructions given the patient in the use of his eyes; when we see a case of glaucoma carried along with change of glasses and the assurance that the patient had cataract and it would ripen at some time, and he could then see a physician and have an operation, and on examination we find that all useful vision has been lost; when we see these and many others that could have been saved after proper diagnosis and treatment, we must get sick at heart and ashamed of some of these vendors. A failure to recognize these diseases through the absence of medical training, subjects the patient to hardships which could be prevented.

In conclusion we may say that poor vision can be due to a diseased condition within or without the eye proper, and its recognition and treatment require the best skill obtainable in medical training. We do not know without thorough examination which of these are the simple headaches and poor visions due to optical defects and the one due to some pathological condition within or without the eye that must be treated according to the indication of the case in hand, but which require more in treatment than simply a pair of glasses.

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#### PROPAGANDA FOR REFORM.

CARE IN ADMINISTERING ARSPHENAMINE.  
—More than the ordinary severe reactions from arspenamine have been reported lately; hence there is need of special care at the present time in the administration of arspenamine. The question may justly be raised if it is wise to repeat the administra-

tion at very short intervals. There also are indications to suggest the wisdom of beginning with small doses. Also, while heat may be used in dissolving the arsenobenzol brand of arsphenamine, it should be avoided in the case of the other brands which are readily soluble in water. (*Jour. A. M. A.*, June 15, 1911, p. 1867.)

**COTARNIN HYDROCHLORID.**—P. J. Hanzlik reports that while the description of the actions and uses of cotarnin hydrochlorid given in New and Nonofficial Remedies tentatively accepts certain current statements in the absence of definite published data, experiments with animals carried out by him demonstrate that the drug is devoid of hemostatic action. He holds that cotarnin hydrochlorid is entirely worthless as a local hemostatic. (*Jour. A. M. A.*, June 15, 1918, p. 1883.)

**MICROCOCCUS NEOFORMANS VACCINE.**—This was admitted to New and Nonofficial Remedies in 1910 since at that time it gave some promise of therapeutic value. It has now been omitted because at the present time there is no evidence that the vaccine is of the slightest value and because its lack of value is demonstrated by the fact that during these years it has not made a recognized place for itself in therapeutics. The available information indicates that the micrococcus neoformans does not differ materially from ordinary skin cocci which are described in New and Nonofficial Remedies under staphylococcus vaccine. (Reports of the Council on Pharmacy and Chemistry, 1917, p. 152.)

**MISBRANDED NOSTRUMS.**—The following preparations have been investigated by the Federal authorities and their proprietors convicted of misbranding under the Federal Food and Drugs Act: Dr. Swan's Liver and Kidney Remedy, containing alcohol, sugar, glycerin, sodium salicylate, strychnin and some laxative plant drug, with indications of juniper. Stuart's Calcium Wafers, containing strychnin, despite the claim that it contained no poisonous ingredient. Turpentine Man's or Tyding's Remedy, a glucose sirup

containing potassium iodid, alcohol and traces of salicylic acid, phosphates, calcium and alkaloids. Henry's Red Gum Compound, containing heroin, chloroform, alcohol, glycerin and sugar. Athlophoros, a solution of glycerin, sodium salicylate, oil of cinnamon and water. Dr. Thatcher's Cholera Mixture, containing alcohol, morphin, a laxative drug, sugar and aromatics. Dr. Thatcher's Amber Injection, containing alcohol, opium and zinc sulphate to which acetic acid had been added. Abbott Bros.' Rheumatic Remedy, containing 24 per cent alcohol with 5 grains potassium iodid to each teaspoonful with extracts of drugs such as sarsaparilla and dandelion. (*Jour. A. M. A.*, June 1, 1918, p. 1624.)

**ORCHIS EXTRACT.**—A post-office fraud order has been issued against Fred A. Leach, doing business as the Packers' Product Company, Chicago. The business which the post-office has declared a fraud consisted in the sale of Orchis Extract, claimed to be a remedy for lost sexual powers, etc. The Federal chemists found that Orchis Extract tablets consisted of milk sugar, orchitic animal tissue, and agents used in compressing the tablets. (*Jour. A. M. A.*, June 8, 1918, p. 1786.)

**NU-TONE.**—This "nutritive tonic" is said to have the following complex composition: Cod liver oil, pure Norwegian, 25 per cent, malt extract, 9 1-3 per cent, beef juice, glycerine, hypophosphite lime, hypophosphite soda, chemically pure, 1 1-2 grains each to the ounce, fl. ext. nux vomica, 3-64 of a minim in each teaspoonful. It is advertised with claims that will lead thoughtless physicians and a confiding public to depend on it in cases in which fresh air, hygienic surroundings and nutritious food are of prime importance. Adults are to take this preparation as a "nutritive" in doses which represent from 3 to 12 grains of sugar and 8 to 30 minims of cod liver oil with unstated, but probably equally small, amounts of beef juice. The Council on Pharmacy and Chemistry declared Nu-Tone inadmissible to New and Nonofficial Remedies because it is



an irrational, shotgun mixture advertised indirectly to the public with unwarranted therapeutic claims and non-descriptive therapeutically suggestive name. (Reports of the Council on Pharmacy and Chemistry, 1917, p. 154.)

SEVERAL "MIXED" VACCINES NOT ADMITTED TO N. N. R.—The Council on Pharmacy and Chemistry publishes a report announcing the rejection of a number of "mixed" vaccines. In publishing its report the Council explains its attitude toward this class of products: In view of the rapid development of bacterial therapy, the possibility for harm that attends the use of bacterial vaccines and the skepticism among experienced clinicians as to the value of vaccines representing a combination of organisms, the Council has felt that it should scrutinize the claims for such agents with exceptional care and admit to New and Non-official Remedies only those vaccine mixtures for which there is acceptable evidence to indicate that the particular mixture is rational. Experienced clinicians have generally come to the conclusion that mixed vaccines have no specific action and that any effect they may produce is due to a non-specific protein reaction. The preparations rejected in the accompanying reports are only a few of the many that are being sold by some biological houses. The report explains in detail the considerations which led to the rejection of the following preparations, all of which were considered because of inquiry received: (1) The Abbott Laboratories: M. Cattarhalis-Combined-Bacterin, B. Coli-Combined-Bacterin, Pertussis-Combined-Bacterin, Streptococcus-Rheumaticus-Combined-Bacterin and Streptococcus-Viridans-Combined Bacterin. (2) Eli Lilly and Company: Catarrhal Vaccine Combined and Influenza Vaccine Combined. (3) H. K. Mulford Company: Influenza Serobacterin Mixed. (4) G. H. Sherman: Sherman's Mixed Vaccine No. 40: (*Jour. A. M. A.*, June 22, 1918, p. 1967.)

SODIUM VERSUS POTASSIUM.—When the embargo was declared on Germany, the price of potassium salts in this country began to soar. Now steps are being taken for the production of potassium in this country. In the meantime the plentiful sodium salts may, in most cases, be used instead. There is no evidence that potassium salts are superior therapeutically to sodium salts, and they are very much cheaper. Sodium acetate, sodium bicarbonate, sodium bromid, sodium chlorate and sodium hydroxid are among the sodium salts which may with advantage replace the corresponding potassium salts. (*Jour. A. M. A.*, June 1, 1918, p. 1601.)

SODIUM BICARBONATE.—Few patients will object to the taste of sodium bicarbonate if the required dose is administered dissolved in a convenient quantity of cold water. The taste may be disguised by dissolving the sodium bicarbonate in carbonated water or else by adding a little sugar and lemon juice to ordinary water. Sodium bicarbonate may also be prescribed in the form of tablets. Though it is better that these be allowed to dissolve in the mouth, in most cases they are swallowed without discomfort. (*Jour. A. M. A.*, Feb. 9, 1918, p. 410.)

SYPHILODOL.—According to the French Medicinal Company, New York, Syphilodol is a "synthetic chemical product of silver, arsenic and antimony," the effects of which are very similar to those of salvarsan and neosalvarsan, with the advantage that, in addition to being available in ampules for intramuscular or intravenous use, it is also furnished in the form of tablets for oral administration. The A. M. A. Chemical Laboratory reports that each Syphilodol tablet contained approximately  $\frac{3}{4}$  grain yellow mercurous iodid with minute traces of arsenic, silver and antimony. The laboratory further reports that a Syphilodol ampule contained a liquid having the characteristics of water, in which the presence of less than  $\frac{1}{6000}$  grain of arsenic could be demonstrated. Shorn of its mystery, Syphilodol therefore is essentially the old, well-

known "protoiodid of mercury." (*Jour. A. M. A.*, May 18, 1918, p. 1485.)

**THYROID HYPERPLASIA AND IODIN.**—The evidence indicates that simple goiter is associated with a deficiency of iodine in the thyroid gland and that goiter formation may be prevented by iodine administration. Marine and Kimball have undertaken a study of goiter prevalence and its prevention by administration of iodine at the request of the Committee on Therapeutic Research of the Council on Pharmacy and Chemistry. In a complete census of the condition of the thyroid gland in girls from the fifth to the twelfth grades of a school population of a large community at the southern edge of the Great Lakes goiter district, they found that 2,184 or 56 per cent had enlarged thyroids, 13 per cent having well defined persistent thyroglossal stalks. (*Jour. A. M. A.*, March 23, 1918, p. 848.)

**THE TOXICITY OF ARSPHENAMIN (Salvarsan).**—James C. Sargent, Milwaukee, Wis., and J. D. Willis, Roanoke, Va., report untoward effects from the intravenous administration of American-made salvarsan (arsphenamin). Such experiences are not unusual, but should be reported. Untoward results followed the use of the German salvarsan. Such reactions may be due to faulty preparation, to deterioration of certain ampules of a batch, to idiosyncrasy of the patient or to faulty technic or preparation or injection. There is no reason to believe that the arsphenamin made in this country is more toxic or less satisfactory than that formerly imported from abroad. (*Jour. A. M. A.*, April 27, 1918, p. 1254.)

**UNCTOL.**—This is a paste stated by the R. R. Rogers Chemical Co., San Francisco, Cal., to contain approximately 40 per cent metallic mercury in a soap base. It is sold as a substitute for mercurial ointment with the claim that it is more efficacious. The Council on Pharmacy and Chemistry declared Unctol inadmissible to New and Nonofficial Remedies because the claim for superiority over mercurial ointment is not substantiated and con-

stitutes an unwarranted therapeutic claim; the name does not indicate the composition of this pharmaceutical mixture and because the circular wrapped with the trade package advertises proprietary preparations not accepted by the Council. (Reports of the Council on Pharmacy and Chemistry, 1917, p. 162.)

**V-E-M PRODUCTS.**—The Schoonmaker Laboratories, Inc., New York, market V-E-M Unguentum Eucalyptol Compound, V-E-M with Ichthyol, V-E-M with Stearate of Zinc, V-E-M with Camphor, V-E-M with Boric Acid. The Council on Pharmacy and Chemistry declared these preparations in conflict with its rules because unwarranted therapeutic claims were made for them; because the public was advised to depend on them in the treatment of diseases, and because these combinations of ingredients in fixed proportions under proprietary names are irrational. (Reports Council on Pharmacy and Chemistry, 1917, p. 163.)

**WHEELER'S TISSUE PHOSPHATES.**—This is advertised as a "nerve food" and a "nutritive tonic." L. E. Warren, of the A. M. A. Chemical Laboratory, has analyzed this semi-secret proprietary and reports that it is a mildly bitter, flavored syrup which contains nearly 12 per cent of alcohol, small quantities each of calcium phosphate and hydrochloric acid and insignificant quantities of iron and quinin salts. From the analysis it is evident that Wheeler's Tissue Phosphate is an unscientific, shotgun mixture whose most active and powerful constituent is the alcohol which it contains. (*Jour. A. M. A.*, May 5, 1917, p. 1337.)

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**IT IS NOT NECESSARY TO FORWARD YOUR APPLICATION BLANK FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY, TO THE SURGEON GENERAL. PRESENT IT, TOGETHER WITH THE OTHER PAPERS REQUIRED BY REGULATIONS, TO THE EXAMINING BOARD AT THE TIME YOU APPEAR FOR EXAMINATION.**

APPLICATION FOR APPOINTMENT  
IN THE  
MEDICAL RESERVE CORPS, U. S. ARMY

To the SURGEON GENERAL, U. S. Army,  
Washington, D. C.  
Sir :

I hereby make application to be examined for appointment in the Medical Reserve Corps, U. S. Army, and inclose testimonials as to my character and habits.\*

I certify that to the best of my knowledge and belief I am laboring under no mental or physical infirmity or disability which can interfere with the efficient discharge of any duty which may be required of me if appointed in the Medical Reserve Corps, U. S. Army, and that the answers given to the interrogatories below are true and correct in every respect.

I furthermore state my willingness to proceed to such point for examination as may be designated by the Surgeon General, with the understanding that the journey entailed thereby must be made at my own expense.

INTERROGATORIES.

1. What is your name in full (including your full middle name)?.....
2. What was the date of your birth?.....
3. Where were you born? (Give State and city or county; if foreign born, give country).....
4. When and where were you naturalized? (For applicants of alien birth only.).....
5. Are you married or single?..... 6. Have you any minor children; if so, how many?.....
7. What is your height, in inches?..... 8. Your weight, in pounds?.....
9. Give the nature and dates of all serious sicknesses and injuries which you have suffered?.....
10. If either parent or brother or sister has died, state cause and age in each case:.....
11. Do you use intoxicating liquors or narcotics; if so, to what extent?.....
12. Have you found your health or habits to interfere with your success in civil life?.....
13. What academy, high school, college, or university have you attended? State periods of attendance from year to year, and whether you were graduated, giving date or dates of graduation:.....
14. Name any other educational advantages you have had, such as private tuition, foreign travel, etc.:.....
15. Give all literary or scientific degrees you have taken, if any, names of institutions granting them, and dates: .....
16. With what ancient or modern languages or branches of science are you acquainted?.....

\*Testimonials as to character and habits from at least two reputable persons must accompany this application. Political recommendations are not necessary.



17. How many courses of lectures have you attended?..... Names of colleges and dates :  
.....
18. When and where were you graduated in medicine? .....
19. Have you been before a State examining board? If so, state when, where and with what result : \* .....
20. Are you a member of any State medical society? If so, give its name :.....  
.....
21. Have you had service in a hospital? If so, state where and in what capacity, giving inclusive dates of each kind of service :.....  
.....
22. What clinical experience have you had in dispensary or private practice?.....
23. Have you paid particular attention to any specialty in medicine; if so, what branch?.....
24. What opportunities for instruction or practice in operative surgery have you had?.....  
.....
25. Have you previously been an applicant for entry into the United States service? If so, state when, where, and with what result (if rejected state why) : .....
26. Are you a member of the organized militia? If so, state with what organization and in what capacity : .....
27. Have you been in the military or naval service of the United States as cadet or otherwise? If so, give inclusive dates of service with each organization, designating it :.....  
.....
28. What occupation, if any, have you followed other than that of student or practitioner?.....  
.....
29. What is your present post-office address?.....
30. What is your permanent residence?.....
31. (Signature of applicant.).....
32. The correctness of all the statements made above was subscribed and sworn to by the applicant before me this.....day of....., 191.....  
.....  
.....

\*This application must be accompanied by a certificate from the proper official that the applicant is duly registered to practice medicine in the State in which he resides.

FORM 149  
W. D., S. G. O.  
(Revised May 3, 1917)

APPLICATION FOR EXAMINATION FOR APPOINTMENT IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

.....Inclosures.

## The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or P. O. Box 16, Jacksonville, Fla., U. S. A.

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(To be selected).

## A BRITISH VIEW OF THE AMERICAN MEDICAL ASSOCIATION'S WAR ACTIVITIES.

The *British Medical Journal* (June 1) comments on the editorials which appeared in *The Journal*, April 20 and 27, relative to the call of Surgeon-General Gorgas for five thousand more medical officers. Our confrère observes that the American Medical Association offered its services to the government at the time the United States entered the war just as did the British Medical Association at the beginning of the conflict, and intimates that we are going through their experience when we call only for a sufficient number of volunteers to meet immediate needs. As to this, of course the Surgeon-General is not endeavoring to supply the immediate needs, because these have been supplied; what the Surgeon-General desires is to prepare for future needs. Incidentally we might add that this need may not be far distant, judging from the outlook for rapid enlargement of our National Army.

Referring to the call of our Surgeon-General, the *British Medical Journal* says: "The American Medical Association, like the British Medical Association, has a War Committee which is taking up this call with energy and enthusiasm. The Surgeon-General desires that the five thousand shall be secured without serious hardship to any community, manufacturing concern or other civil activity, and consequently the American Medical Association has begun to investigate the conditions in all parts of the country so as to produce a survey which will 'provide a basis for accurate, intelligent, cooperative effort.'" It goes on to say that our War Committee, as did theirs, deliberated on the advisability of calling for a voluntary draft, which would mean that every physician in active practice would volunteer as a member of the Medical Reserve Corps and be subject to call. "The American Medical Association has deemed this extreme measure [that is, voluntary draft] unnecessary for the present

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at least. The organization of such a scheme would have afforded excellent training for the work the Association will have to face if ever it becomes necessary in America to pass a military service act in any way comparable to that which has been found necessary in Great Britain." However, attention is called to the relatively large number of medical practitioners in America as compared with the number in Great Britain.

Quoting our statement that "the time has come for every medical man under 55 years of age who is physically qualified to consider seriously for himself the question of his duty to his government," the *British Medical Journal* suggests that "no individual practitioner can possibly judge for himself the medical needs of the community in which he practices or the hardship which he himself will suffer." This fact is being recognized in the work being done by the state and county organizations. It is appreciated that even the county society, except where the county includes large centers of population and consequently a large number of physicians, is seldom qualified to pass judicially on the question as to whether such and such a man could be spared or should offer his services. The plan now being tested out in some of the Councilor Districts of Nebraska is more likely to result in judicious conservative selection, with personal bias eliminated. There, as mentioned elsewhere in this issue, it is proposed that a committee composed of a representative from each county society in the Councilor District, with the councilor of the district acting as chairman, shall indicate those who should apply for commission and in what order, so that the quota assigned to that district will be available.—*Jour. A. M. A.*

#### MEDICAL SUPERVISION FOR INDUSTRIAL WORKERS.

In pleading for the assurance of the efficiency and welfare of the girls and women who are entering on men's occupation as an inevitable consequence of the world war,

Josephine Goldmark<sup>1</sup> of the National Consumers' League has emphasized three safeguards, namely, equal wages, additional legislation, and adequate medical supervision. With the rapidly increasing demand for physicians in connection with the enormous expansion of the Army and Navy, it might seem as if a call for greater medical effort among the civilian population were an ill timed if not ill advised scheme. We need to keep in mind, however, that the nation's great industrial army also must be maintained in a high degree of physical competence if the supreme effort is to be most successfully carried out. With the experience of the allied nations to guide us, America can not afford to overlook this important feature. Competent medical supervision may do even more than facilitate the nation's self-preservation. Industrial clinics and all forms of medical supervision are inevitably agencies for public enlightenment in matters of hygiene. Moreover, they strike a blow at the insidious inroads of quackery and nostrum venders. Dr. Beatrice Webb, whose work for the Health of Munition Workers' Committee of the British Ministry of Munitions has given her unusual opportunities to become familiar with the life and health of the thousands of women and girls brought into the factories, has indicated some of the current tendencies. A widely spread and highly dangerous habit, she writes,<sup>2</sup> has arisen and is rapidly growing, of taking medicines, recommended by advertisement, by friends, or prescribed by physicians in bondage to the custom of seeing large numbers of patients in a short space of time. The spread of the habit of self-medication is attributed in part to the migration from rural to urban districts, where conditions are less favorable for right living. Dr. Webb points out, furthermore, that the ubiquitous advertisement of "patent medicines" can not be without

1. Goldmark, Josephine: Some Considerations Affecting the Replacement of Men by Women Workers, *Am. Jour. Pub. Health*, 1918, 8, 270.

2. Webb, Beatrice: *Health of Working Girls*, London, 1917.



consequence. This can only be met by a counter campaign of education and, we believe, by the provision of suitable medical advisory opportunities. This is not synonymous with the prescription of drugs; rather, it means the establishment of suitable agencies which shall proclaim and teach right rules of living and help to correct remediable defects in accordance with modern medicine. When Voltaire described a physician as "a man who puts drugs of which he knows little into bodies of which he knows less," he doubtless delivered a reproach that was in part deserved. A prominent duty of the medical profession today should be to try to keep people well and to raise the general level of health. This brings us back to the original proposition: equal wages, additional legislation, and adequate medical supervision for the industrial workers.—*Jour. A. M. A.*

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#### THE PRESIDENT-ELECT, MAJOR ALEXANDER LAMBERT.

The president-elect of the American Medical Association, Major Alexander Lambert, M. R. C., U. S. Army, is already en route again to France to resume his duties as medical director for the Red Cross. Major Lambert is a member of a noted medical family. His father, Dr. Edward W. Lambert, an executive of ability, was for forty-five years chief medical adviser of the Equitable Life Assurance Society. This executive ability Major Lambert seems to have inherited to a remarkable degree, as indicated by his achievements. Dr. Lambert was born December 15, 1861, and received his A. B. from Yale in 1884, his Ph.D. in 1885, and his M. D. degree from the College of Physicians and Surgeons of Columbia University in 1888. After two years' service as an intern in Bellevue Hospital he entered on the active

practice of his profession. He became attending physician at Bellevue Hospital in 1894, served as assistant bacteriologist in the New York Health Department from 1894 to 1901, and since 1898 has been professor of clinical medicine in the Cornell University Medical College. He has been attending and consulting physician in several New York hospitals, and is recognized especially for his work in circulatory diseases and in the treatment of drug and alcohol addictions. In the American Medical Association he has served in the House of Delegates as a representative of the great state of New York, became a member of the judicial council in 1911, and has been chairman of that body since 1912. As chairman of this council he worked in co-operation with a committee of the Council on Health and Public Instruction in the compilation of much material and in the issuing of notable reports on workmen's compensation and health insurance. In 1917 he became president of the Medical Society of the State of New York. Since 1907 he has been a member of the Medical Reserve Corps of the United States Army; a brief month after the United States entered the war he was ordered to active duty in France as deputy commissioner of war relief of the Red Cross and chief medical adviser of all American Red Cross activities in France and Belgium. His election to the presidency of the American Medical Association is but another recognition of services well rendered with an adequate conception of the duties of a physician to himself, to the public, to the state and to the nation. It does not mark, we are sure, the culmination of an already noteworthy career; it is but the placing of an earnest worker in a position in which he can render still greater service to worthy activities.—*Jour. A. M. A.*

STATEMENT OF PHYSICIANS RECOMMENDED FOR COMMISSIONS IN THE MEDICAL RESERVE CORPS, U. S. ARMY.

State.	Number of Physicians in State.	Recommended in corps to July 1st.	Percent Recommended.	Order.
Alabama .....	2,525	366	14.5	44
Arizona .....	331	72	21.8	5
Arkansas .....	2,587	213	8.2	49
California .....	5,396	906	16.8	26
Colorado .....	1,689	234	13.9	45
Connecticut .....	1,679	273	16.3	28
Delaware .....	254	37	14.6	43
District of Columbia	1,054	242	23.0	4
Florida .....	1,283	236	18.4	19
Georgia .....	3,436	539	15.7	35
Idaho .....	449	83	18.5	18
Illinois .....	10,909	1,911	17.5	22
Indiana .....	4,763	699	14.6	42
Iowa .....	4,004	534	13.3	46
Kansas .....	2,668	433	16.2	29
Kentucky .....	3,483	564	16.2	31
Louisiana .....	2,025	323	15.9	34
Maine .....	1,179	148	12.6	47
Maryland .....	2,268	475	20.9	8
Massachusetts .....	5,870	952	16.2	30
Michigan .....	4,598	834	18.1	20
Minnesota .....	2,584	535	20.7	9
Mississippi .....	1,975	317	16.1	33
Missouri .....	6,063	1,099	18.1	21
Montana .....	661	166	25.1	2
Nebraska .....	1,565	380	24.3	3
Nevada .....	152	42	27.6	1
New Hampshire ....	657	100	15.2	38
New Jersey .....	3,046	630	20.7	10
New Mexico .....	456	77	16.9	25
New York .....	15,877	3,081	19.4	14
North Carolina ....	2,237	389	17.4	24
North Dakota .....	604	122	20.2	12
Ohio .....	7,821	1,151	14.7	41
Oklahoma .....	2,672	431	16.1	32
Oregon .....	1,128	236	20.9	6
Pennsylvania .....	11,539	2,418	20.9	7
Rhode Island .....	759	114	15.0	40
South Carolina .....	1,237	231	18.7	16
South Dakota .....	646	132	20.4	11
Tennessee .....	3,481	530	15.2	39
Texas .....	6,236	972	15.6	36
Utah .....	477	73	15.3	37
Vermont .....	639	119	18.6	17
Virginia .....	2,509	418	16.7	27
Washington .....	1,673	320	19.1	15
West Virginia .....	1,759	306	17.4	23
Wisconsin .....	2,783	549	19.7	13
Wyoming .....	254	28	11.0	48

These percentages are based on a recount of the number of physicians registered and the number recommended for commission.

RED CROSS NEEDS MEDICAL MEN ABROAD.

The American Red Cross needs physicians and surgeons for its work abroad. The Medical Reserve Corps of the Army takes precedence over all other calls but there must be men who, rejected for slight physical disability or for being between 55 and 60 years of age, should be available for the various medical duties of the Red Cross. The teaching staff of the medical schools will not be taken unless with the written permission of the dean. Medical men are wanted for clinical work in medicine and surgery, for administration work, for hospital administration, and for the medical work in the manifold Red Cross activities. All who can go as volunteers, paying all their expenses, should do so to aid the Red Cross; but if this is impossible, the Red Cross is prepared to pay their expenses and, when necessary, to add the salary of a first lieutenant—\$160 a month. It will be possible to have men go for work in the Red Cross for eight or nine months abroad and six months home, and again eight months abroad, thus having a rotating service as regards personnel, but a continuous medical service. All applications should be made to Dr. Alfred E. Shepley, Medical Personnel Bureau, Red Cross, Washington, D. C.

ALEXANDER LAMBERT.

Chief Medical Adviser, Red Cross in France.  
4 Place de la Concorde, Paris.

—*Jour. A. M. A.*

SOME FACTS ABOUT YEAST.

The subject of yeast is of importance because, first, as has been pointed out in an editorial article in the *Journal of the American Medical Association* (1916, LXIV, 1390), it possesses a distinct nutritive value, and because, secondly, it possesses therapeutic qualities. It is about some of the forms of yeast and their therapeutic properties that we wish to write. The matter of yeast treatment has recently received impetus as the result of the publication in the *Journal of the*

*American Medical Association* (October 13, 1917) of an article by Dr. Philip B. Hawk and collaborators, which represents work done in the Laboratory of Physiological Chemistry of the Jefferson Medical College and the Philadelphia General Hospital, both of Philadelphia, and the Roosevelt Hospital, New York.

Hawk and his colleagues obtained strikingly good results from the use of yeast in many pathological conditions, especially the purulent skin conditions such as acne and furunculosis and in constipation. That they did so is not at all surprising, for yeast has always acted well in these skin conditions, as is well known. Hawk mentions that yeast has been used in medicine since the days of Hippocrates (who used it in the treatment of leucorrhea); not, however, until the middle of the nineteenth century was its use looked on favorably by the medical profession. Since then its value has been attested by numerous observers, who have employed it in a variety of pathological conditions. Its value in certain skin conditions has been freely acknowledged by dermatologists—for instance, Schamberg has seen good results from its use in the treatment of ordinary furunculosis (*Diseases of the Skin and the Eruptive Fevers*, 1915), although it failed him in the furunculosis accompanying smallpox.

Hawk's researches are novel in that he employed as a therapeutic agent not the time-honored brewers' yeast, but the familiar Fleischmann's yeast of the bakeries and the household. This is the first time, it seems, that bakers' yeast has been employed systematically as a therapeutic agent, although Louvel (*Rennes Med.*, 1905-6, fasc. 10, 16-19) seems to have used it in the treatment of sundry infectious diseases, and according to Cailliau (*Thèse de Paris*, 1908) it was used in 1896 by De Backer, who mixed it with equal parts by weight of white honey, and who, having used it thus in the treatment of furunculosis, considered that it was more ac-

tive and better supported than ordinary yeast.

That brewers' yeast should have been used in the past is not at all surprising when we call to mind that, in all probability, in modern times at least, it was extensively used and tested by the employees of breweries, who found it readily accessible. A special virtue seems to have attached to brewers' yeast, probably from this reason. For instance, the yeast specified by Schamberg (*loc. cit.*) is fresh brewers' yeast, and the U. S. Pharmacopœia of 1876 defines yeast (*fermentum*) as "a peculiar insoluble product of the fermentation of malt liquors." It was dropped from the Pharmacopœia of 1880, and has since remained unofficial. The U. S. Dispensatory (Remington and Wood) of 1918 describes it as a "flocculent, frothy, somewhat viscid semi-fluid of a dirty yellowish color, a sour vinous odor and a bitter taste." Suffice it to say, the appearance of brewers' yeast is not at all familiar to very many physicians, one reason being that it is not immediately available, except in some large cities. In country districts that are remote from breweries the use of brewers' yeast is attended with serious difficulties.

Compressed yeast, the undried product, is readily obtained and there is no reason why it should not be largely used.

The National Formulary, 1916, under the term "*Cerevisiæ Fermentum Compressum*," recognizes compressed yeast and describes it as follows: "The moist, living cells of *Saccharomyces cerevisiæ* Meyen (Fam. *Saccharomycetaceæ*) or of other species of *Saccharomyces*, combined with a starchy or absorbent base. White or yellowish-white, soft, and easily broken masses, having a characteristic slightly sour odor, and not more than a faintly acid reaction to litmus. When examined under the microscope, numerous oidium and mycoderma cells and starch grains are visible. Compressed yeast must not be used unless fresh, and free from mildew and musty odors." Sadtler (*Industrial Organic Chemistry*, 1900) has also



given a good description of compressed yeast: "It should be only slightly moist, not sloppy to the touch; the color should be a creamy white; when broken it should show a fine fracture; when placed upon the tongue it should melt readily in the mouth. It should have an odor of apples, not like that of cheese; neither should it have an acid taste or odor \* \* \*."

A certain disadvantage of fresh brewers' yeast in therapeutics has been mentioned, *i. e.*, its non-availability. Certain other objections to its use readily come to mind, among them being the fact that as a rule it is decidedly non-uniform both as to composition and as to action. We would readily suspect this when we recollect that in the yeast of the breweries two well-marked varieties of *Saccharomyces* have been recognized; a top yeast most active at 16° to 20° C. and a bottom yeast most active at 6° to 8° C. On the different behavior of these varieties, different methods of brewing have been founded. Lardier (Thèse de Paris, 1901-1902) calls attention to the fact that brewers' yeasts obtained from different breweries behave differently so far as therapeutic action is concerned; moreover, that the therapeutic action of yeasts obtained from different barrels in the same brewery varies. Also the yeast in the same barrel varies at different stages of fermentation. He states that the difference explains in part the varying therapeutic results of different observers.

Besides varying in proportions of the different species of *Saccharomyces* they contain, brewers' yeasts are apt to be admixed with various wild yeasts that enter the liquid from the air.

There is a difference of opinion concerning the nature of the constituent of the yeast which gives it therapeutic value. Some investigators claim a direct bactericidal effect, others regard such effect as due to by-products of fermentation such as alcohol and various acids, still others regard the action as due to the chemotactic influence of the high nuclein content of the yeast. According

to the Dispensatory, the experiments of Walzou and Sacharow have shown that yeast increased the opsonic index of dogs for staphylococci and streptococci. This may help to explain its favorable action in infectious conditions.

The Dispensatory mentions the fact that the ordinary yeast cake of American bakers may well be substituted for brewers' yeast. In view of Hawk's investigations this statement may very well be true. Compressed yeast is generally to be preferred because of the fact that it is carefully standardized and a uniform product is always obtainable. Sadtler refers to the researches of Hansen, who early separated various species of yeasts used in the industries. Among these varieties of *Saccharomyces*, cerevisial and *Saccharomyces Patorinus* were used in the brewing of beer, *Saccharomyces ellipsoides* in the manufacture of wine. Sadtler states that it is prepared as compressed yeast in cakes, generally with the addition of potato-starch. The National Formulary does permit the presence of species of *Saccharomycetaceæ* other than *Sacchyomyces cerevisiæ* Meyen. At all events, the composition of bakers' yeast can be controlled, and this yeast possesses the advantages of availability and uniformity.

#### OUR HONOR ROLL.

Our Honor Roll as published below now constitutes a grand total of one hundred and fifty-four physicians. They are divided in the services as follows: Medical Corps—Lieutenant Colonel, 1; Medical Corps, National Army—Lieutenant Colonel, 1; Medical Reserve Corps—Majors, 14; Captains, 29; 1st Lieutenants, 95; total, 140. United States Navy—Passed Assistant Surgeons, 2; Assistant Surgeons, 4; total, 6. National Guard United States (Fla.)—Majors, 3; Captain, 1; 1st Lieutenants, 4; total, 8.

#### MEDICAL CORPS, U. S. ARMY.

*Home Address.*  
Lieut.-Colonel Joseph Y. Porter.....Key West

#### MEDICAL CORPS, NATIONAL ARMY.

Lieut.Colonel Raymond C. Turck.....Jacksonville

## MEDICAL RESERVE CORPS.

Major Frank E. Artaud.....	Key West	1st Lieut. Fay A. Cameron .....	Tampa
Major M. H. Axline.....	St. Petersburg	1st Lieut. Chauncey L. Chase .....	Fort Dade
Major John E. Boyd .....	Jacksonville	1st Lieut. Joseph H. Chiles .....	Cleremont
Major Frederick G. Barfield.....	Jacksonville	1st Lieut. William A. Clark.....	Pine Barren
Major Chauncey L. Chase .....	Fort Dade	1st Lieut. J. S. Coker.....	Gardner
Major Stanley Erwin .....	Jacksonville	1st Lieut. Henry B. Cordes .....	Jacksonville
Major James B. Griffin.....	St. Augustine	1st Lieut. Charles S. Cooper.....	St. Cloud
Major H. H. Harris.....	Jacksonville	1st Lieut. Wallace P. Crigler .....	Ocala
Major Graham E. Henson.....	Jacksonville	1st Lieut. T. G. Croft .....	Jacksonville
Major Frederick E. Jenkins.....	Palatka	1st Lieut. Clinton W. D'Alemberte .....	Pensacola
Major Frank R. Maura.....	Ojus	1st Lieut. James S. Davidson .....	Clearwater
Major Lucien B. Mitchell.....	Tampa	1st Lieut. Kenneth McC. Davis.....	Westbay
Major Harry Peyton .....	Jacksonville	1st Lieut. Gaston Day .....	Jacksonville
Major George A. Plummer.....	Key West	1st Lieut. L. B. Dickerson .....	Clearwater
Captain A. E. Acker.....	Jacksonville	1st Lieut. George W. Dupree.....	Blue Creek
Captain E. G. Birge .....	Jacksonville	1st Lieut. William T. Elmore .....	Gainesville
Captain H. O. Black .....	Jacksonville	1st Lieut. Orin O. Feaster .....	Mulberry
Captain Andrew R. Bond .....	Tampa	1st Lieut. Nacy L. Gachet .....	Century
Captain O. L. Callahan .....	Mt. Dora	1st Lieut. Claude V. Gautier.....	Passagrille
Captain T. Z. Cason.....	Jacksonville	1st Lieut. Hugh St. C. Geiger.....	Kissimmee
Captain Lester J. Efird .....	Tampa	1st Lieut. H. M. Ginsberg .....	Pensacola
Captain Albert H. Freeman .....	Starke	1st Lieut. Paul Goss .....	Mulberry
Captain Julian Gammon .....	Jacksonville	1st Lieut. O. F. Green .....	Mayo
Captain J. Halton .....	Sarasota	1st Lieut. John D. Griffin .....	Lakeland
Captain Henry Hanson .....	Jacksonville	1st Lieut. G. H. Gwynn, Jr.....	Tallahassee
Captain Maurice E. Heck.....	St. Augustine	1st Lieut. Humphrey Gwynn .....	Tallahassee
Captain Samuel G. Hollingsworth.....	Bradentown	1st Lieut. J. H. Hall.....	Sopchoppy
Captain Owen H. Kenan .....	Palm Beach	1st Lieut. John Halliday .....	Tampa
Captain S. M. R. Kennedy.....	Pensacola	1st Lieut. Drew R. Handley .....	Jacksonville
Captain William W. Mills .....	Miami	1st Lieut. MacMiller Harrison.....	Palmetto
Captain William B. Moon .....	Lakeland	1st Lieut. John R. Hereford .....	Fort Dade
Captain Frederick C. Moor .....	Tallahassee	1st Lieut. Frank P. Hixon .....	Pensacola
Captain John MacDiarmid .....	DeLand	1st Lieut. John C. Holley .....	Pace
Captain R. B. McLaws.....	Tampa	1st Lieut. H. F. Horne .....	Jacksonville
Captain D. W. McMillan .....	Pensacola	1st Lieut. Roy Howe .....	Daytona
Captain John D. McRae.....	Tampa	1st Lieut. A. L. Izlar .....	Ocala
Captain Thomas A. Neal.....	Sanford	1st Lieut. Edward Jelks .....	Jacksonville
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Captain J. Y. Porter, Jr.....	Key West	1st Lieut. Charles L. Kennon.....	Jacksonville
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1st Lieut. B. A. Burks.....	Titusville	1st Lieut. John A. Newnham .....	Cleremont
		1st Lieut. John K. Norwood .....	Jacksonville

1st Lieut. Bascom H. Palmer.....	Tampa
1st Lieut. Henry E. Parnell.....	Fort Myers
1st Lieut. Archie R. Parrott .....	Jacksonville
1st Lieut. James L. Pennington.....	Fountain
1st Lieut. J. O. Philips .....	Worthington Springs
1st Lieut. William H. Pickett.....	Gainesville
1st Lieut. Harper L. Proctor .....	Jacksonville
1st Lieut. Marion E. Quina .....	Pensacola
1st Lieut. Shaler A. Richardson .....	Jacksonville
1st Lieut. Dwight M. Rivers.....	Lake City
1st Lieut. E. T. Sellers .....	Jacksonville
1st Lieut. George W. Sherouse .....	Campville
1st Lieut. E. E. Strickland .....	Miccosukie
1st Lieut. Baldwin S. Stutts .....	Port St. Joe
1st Lieut. G. C. Tillman .....	Gainesville
1st Lieut. W. J. Vinson .....	Tarpon Springs
1st Lieut. Harry C. VonDahm.....	Jacksonville
1st Lieut. Adam C. Walkup .....	McIntosh
1st Lieut. Archie Watson .....	Live Oak
1st Lieut. B. L. Whitten .....	Fort Pierce
1st Lieut. John M. Whitfield .....	Malone
1st Lieut. William E. Whitlock.....	Fort White
1st Lieut. Charlton C. Whittle .....	Nocatee
1st Lieut. Daniel B. Williams .....	Lake City
1st Lieut. Albert H. Wilkinson.....	Jacksonville

#### THE NAVY.

Passed Assistant Surgeon W. P. Dey..	Jacksonville
Assistant Surgeon Thomas S. Field....	Jacksonville
Assistant Surgeon Boyd Gilbert.....	Pensacola
Assistant Surgeon R. P. Henderson.....	Tampa
Passed Asst. Surgeon J. Knox Simpson,	Jacksonville
Assistant Surgeon D. C. Thompson.....	Pensacola

NATIONAL GUARD UNITED STATES (FLA.).	
Major Lorin Green .....	Jacksonville
Major Ralph Green .....	Jacksonville
Major James H. Livingston .....	Jacksonville
Captain W. J. Buck .....	Gainesville
1st Lieut. Daniel C. Campbell.....	Marianna
1st Lieut. John R. Hawkins .....	Williston
1st Lieut. Z. V. Johnson .....	Milton
1st Lieut. J. M. Mitchell .....	Millville

#### PREOPERATIVE PURGATION.

The recent communication by Peet<sup>1</sup> in *The Journal*, relating to the subject of catharsis before surgical operations, supplements the contentions of Alvarez<sup>2</sup> of the Hooper Foundation for Medical Research that purgation as a routine preoperative procedure should be abolished. In his studies on the intestine, Alvarez had noted that after vigorous catharsis the isolated musculature is no longer as responsive as normally to stimuli

and is fatigued with greater readiness. The bowel as a whole may become unduly filled with gas and fluid, the circulation of the intestine somewhat impaired, and the peristalsis deviated from its usual manifestations. In this way it was believed that much of the gas distention, postoperative ileus, and perhaps the nausea and vomiting may be partially accounted for in patients who have undergone surgical operations.

Peet has accentuated the difficulty thus encountered by asking what is expected to be gained through the preparatory evacuation. We suspect that most surgeons would be compelled to answer this query either by a meaningless platitude or by a confession of ignorance. The evidence for a need of or advantage in the customary "emptying" of the bowel by laxatives is, indeed, not easy to find. Sterilization of the interior of the intestine is out of the question as a practical possibility, and there is little indication that anything seriously toxic is removed by such catharsis. On the other hand, it is not unlikely, in view of these studies, that this procedure, attended by fatigue, and often by loss of sleep, is a positive detriment to the patient and an actual cause of some of the familiar postoperative discomfort, if this mild term sufficiently designates the distress referred to. Peet significantly comments on the uneventful convalescence of patients after emergency operations for which no preliminary therapy was instituted.

A further item is worthy of consideration in this connection. Catharsis leads to loss of water and intestinal secretion. If this is not compensated there may be distress from this cause. Crile<sup>3</sup> has lately remarked, in reference to postoperative feeding, that even at

1. Peet, M. M.: Rational Preoperative Treatment with Special Reference to Purgation, *The Journal A. M. A.*, July 20, 1918, p. 175.

2. Alvarez, W. C., and Taylor, F. B.: Changes in Rhythmicity, Irritability and Tone in the Purged Intestine, *Jour. Pharmacol. and Exper. Therap.*, 1917, 10, 365. Alvarez, W. C.: *Surg. Gynec. and Obst.*, 1917, 26, 65.

3. Crile, G. W.: *Dietotherapy*, edited by W. E. Fitch, 1918, 3, 646.



this stage of medical knowledge the supreme value of water is not fully appreciated and its administration is often neglected or mismanaged. How much more serious is this incrimination when preoperative losses are freely induced by purgation. At most, therefore, Peet recommends simple enemas as a means of emptying the bowel before operation. If his contention is correct that, where the more drastic habitual procedure is abandoned, postoperative thirst, nausea and vomiting, abdominal distress and gas pains occur much less frequently, the appeal to abolish something sanctioned by custom deserves to be heeded.—*Jour. A. M. A.*, July 27, 1918.

### CHILD CARE.

Things every mother must know if the Nation is to meet the health needs of its children as indicated by the draft and still further revealed by the weighing and measuring test are made available today by the Children's Bureau of the U. S. Department of Labor in its new bulletin on Child Care, prepared by Mrs. Max West.

A third of the men examined for military service in the first draft were found to have physical defects which rendered them unfit. Many of these defects might have been overcome if they had been recognized and dealt with in early childhood: the period between two and six is often the time when such defects make their first appearance. "Child Care" has been prepared in the hope that it would enable mothers to understand and recognize symptoms which indicate the need of special care, and also to give mothers the better understanding of the simple laws of hygiene through which it may be possible to prevent the development of such defects at all. It will be especially useful to thousands of mothers who have learned by the weighing and measuring test of defects and weaknesses in their children which need particular attention.

"Child Care" deals with children from two to six years old and is the third issue in the

series which began with "Prenatal Care" and "Infant Care." It contains simple rules of health and hygiene, including carefully compiled directions about proper food, suitable clothing, suggestions for play and exercise, for discipline and training. It gives simple menus for young children. A list of books on child care and training is added.

### NEW AND NONOFFICIAL REMEDIES.

ACID. PHENYLCHINCH.-MORGENSTERN.—A brand of phenylcinchoninic acid, U. S. P. It is sold as Tablets Acid. Phenylcinch.-Morgenstern, containing 0.5 gm. acid. phenylcinch., and as Sodium Phenylcinch.-Water-Morgenstern, a solution of sodium phenylcinchoninate containing sodium bicarbonate and sugar and representing the equivalent of 1 gm. Acid. Phenylcinch.-Morgenstern per fluid-ounce.

ANTIPNEUMOCOCCUS SERUM. — A serum obtained from horses immunized with virulent pneumococci. Each lot of antipneumococcic serum is submitted by the manufacturer to the U. S. Hygienic Laboratory for potency test. Early massive (from 50 c. c. to 10 c. c.) intravenous doses of a highly potent serum prepared from the type of pneumococcus present in the case to be treated are necessary. The serum used should be obtained from an animal immunized with pneumococci of the type corresponding to that present in the special case under treatment. Thus far Type I serum alone seems to be on reasonably secure clinical grounds.

ANTIPNEUMOCOCCUS SERUM, Type I, LEDERLE. — Marketed in a pressure syringe containing 50 c. c. Schieffelin and Co., New York.

ANTIPNEUMOCOCCIC SERUM, Type I, P. D. & Co.—Marketed in a piston syringe containing 50 c.c. Parke, Davis & Co., Detroit, Mich.

ANTIPNEUMOCOCCIC SERUM, Type I, SQUIBB.—Marketed in vials containing 50 c. c. E. R. Squibb & Sons, New York.

ANTIPNEUMOCOCCIC SERUM, Type I, CUTTER.—Marketed in vials containing 50 c. c. Cutter Laboratory, Berkeley, Cal.

ANTIPNEUMOCOCCIC SERUM, Type I, MULFORD.—Marketed in double-ended vials containing 50 c. c. H. K. Mulford Co., Philadelphia, Pa.

ANTIPNEUMOCOCCIC SERUM, POLYVALENT, MULFORD.—Prepared by immunizing horses with dead and living pneumococci of the three fixed types (Types I, II, III). Marketed in double-ended vials containing 50 c. c. each, with sterile needle and tubing for intravenous injection. H. K. Mulford Co., Philadelphia, Pa. (*Jour. A. M. A.*, June 22, 1918, p. 1923.)

BACILLEN EMULSION TUBERCULIN, "B. F."—Marketed in 1 c. c. and 3 c. c. vials. Gilliland Laboratories, Ambler, Pa.

BARIUM SULPHATE-BRADY FOR ROENTGEN-RAY WORK.—A brand complying with the N. N. R. standards for barium sulphate for Roentgen-ray work. Geo. W. Brady & Co., Chicago. (*Jour. A. M. A.*, June 1, 1918, p. 1599.)

BOUILLON FILTRATE TUBERCULIN, "B. F."—Marketed in 1 c. c. and 3 c. c. vials. Gilliland Laboratories, Ambler, Pa.

CRESOL-MERCK.—A brand of Cresol, U. S. P. Merck and Co., New York.

CHLORINE SODA AMPULES.—Composed of a sealed glass tube stated to contain 4.8 gm. liquid chlorine and a sealed glass tube stated to contain 21.3 gm. monohydrated sodium carbonate and yielding, when the contents of the tube are dissolved in 1,000 c. c. of water, a solution similar in composition to Neutral Solution of Chlorinated Soda-N. N. R. To prepare the solution the contents of the tube of monohydrated sodium carbonate are placed in a bottle having a capacity of about 2,000 c. c. and dissolved in 1,000 c. c. water. The tube containing the liquid chlorine is suspended from a rubber stopper and is inserted into the bottle and the stopper securely inserted. The large bottle (after covering with a cloth) is shaken to break the chlorine tube, the contents of the bottle are then

shaken for two minutes or longer. The solution freed from particles of glass is ready for use, or its available chlorine may previously be checked by titration. The solution so obtained is intended for the Carrel-Dakin treatment of infected wounds. Johnson and Johnson, New Brunswick, N. J. (*Jour. A. M. A.*, July 6, 1918, p. 939.)

DEXTRI-MALTOSE No. 2, MEAD'S.—A mixture containing approximately maltose, 23.1 per cent; dextrin, 42.6 per cent, and moisture, 4.3 per cent. On the claim that maltose is more readily assimilable than other forms of sugar, Mead's Dextri-Maltose No. 2 is proposed for use in the diet of adult invalids. Mead, Johnson & Co., Evansville, Ind.

DEXTRI-MALTOSE No. 3, MEAD'S.—A mixture containing approximately maltose, 52 per cent; dextrin, 41.7 per cent; potassium carbonate, anhydrous, 2 per cent, and moisture, 4.3 per cent. In the belief that an addition of potassium salts counteracts a tendency to constipation, it is said to be particularly adapted in the feeding of constipated infants. Mead, Johnson & Co., Evansville, Ind. (*Jour. A. M. A.*, July 20, 1918, p. 193.)

GUAIACOL CARBONATE-MERCK.—A brand of guaiacol carbonate, U. S. P. Merck and Co., New York.

PROCAINE-RECTOR.—A brand of procaine complying with the N. N. R. standards. Procaine is the substance which was first introduced as "novocaine." The Rector Chemical Co., Inc., New York.

QUININE DIHYDROCHLORIDE - MERCK. — A brand of quinine dihydrochloride, U. S. P. Merck and Co., New York.

QUININE AND UREA HYDROCHLORIDE-MERCK.—A brand of quinine and urea hydrochloride, U. S. P. Merck and Co., New York.

TUBERCULIN OINTMENT IN CAPSULES (For the Moro Percutaneous Diagnostic Test). — An ointment consisting of tuberculin "Old" and anhydrous wool fat, equal parts. Marketed in capsules sufficient for one test. Gilliland Laboratories, Ambler, Pa.

TUBERCULIN RESIDUE, "T. R."—Marketed in 1 c. c. and 3 c. c. vials. Gilliland Laboratories, Ambler, Pa.

TUBERCULIN FOR THE DETRE DIFFERENTIAL DIAGNOSTIC TEST. — Consisting of one tube each of Original Tuberculin "O. T.," Bouillon Filtrate Tuberculin "B. F.,"

human, and Bouillon Filtrate Tuberculin "B. F.," bovine. Gilliland Laboratories, Ambler, Pa.

THYMOL IODIDE-MERCK. — A brand of thymol iodide, U. S. P. Merck and Co., New York (*Jour. A. M. A.*, April 27, 1918, p. 1225.)

## Publisher's Notes

### FIND ADULTERATED DRUGS.

The officials in charge of the enforcement of the Federal Food and Drugs Act have found certain impurities in pennyroyal leaves. In order that the trade may know what the United States Department of Agriculture regards as adulterants of this product it is proposed that a service and regulatory announcement be issued outlining the opinion of the department. Before issuing the announcement, the department desires to obtain the views of the trade or other interested parties as to the fairness of the ruling. Communications should be addressed promptly to the Bureau of Chemistry, Department of Agriculture, Washington, D. C. All criticisms will receive careful consideration. The proposed announcement follows:

"INFERIOR PENNYROYAL LEAVES. — Examination of samples of pennyroyal leaves, *Hedeoma pulegioides* (Linne) Persoon, has disclosed that in a large number of instances the product has been very carelessly collected and frequently contained very large amounts of sand, stems and other foreign material. From the data at hand, the bureau is of the opinion that properly collected pennyroyal leaves should contain not more than 10 per cent of stems, not more than 16 per cent of total ash and not more than 6 per cent of acid insoluble ash (sand), and will consider as adulterated, under the Food and Drugs Act, any material which does not comply with these figures. Further investigation may reveal the necessity of establishing a more rigid requirement, in which case due notice will be given.

### CHLORETONE: SUGGESTIONS FOR DOSAGE.

For its hypnotic effect Chloretone may be administered in doses sufficient to produce the desired result without endangering the life of the patient. As one writer points out, it is useless to expect to attain that end by giving the patient small doses—5 grains, at long intervals—three times daily. In general, a single dose, of 5 to 20 grains, will have the best effect. It would be well to give about 10 grains the first night, 15 the second, and 20 grains the third. When a dose is found that produces the desired result, the same dose may be repeated until the "sleep habit" has become established, when it should be reduced gradually.

When the use of Chloretone must be continued for a protracted period, as in the treatment of epilepsy, its effects should be watched lest a cumulative action manifest itself. It should not be pushed to the point of dullness and drowsiness.

As a sedative in asthma, chorea, pertussis, nausea, emesis gravidarum, and seasickness, doses of 3 to 10 grains, at stated intervals according to the effect, are generally sufficient. As a preventive of post-anesthetic nausea the administration of ether is the usual practice.

The principal effects of Chloretone are manifested upon the central nervous system. It acts like other hypnotics, but, unlike most of the latter, it does not depress the circulatory system, nor does it disturb digestion.

Chloretone is procurable in 3-grain and 5-



grain capsules, convenient for administration.

### PROCAINE AND NOVOCAINE IDENTICAL.

To the Editor:

It appears that in certain quarters the attitude is taken that the local anesthetic sold as Procaine is not identical with that marketed as Novocaine. The Subcommittee on Synthetic Drugs of the National Research Council believes it important that this misunderstanding should be corrected and hence offers the following explanation:

The monohydrochloride of para-aminobenzoyldiethyl-amino-ethanol, which was formerly made in Germany by the Farbwerke, vorm. Meister, Lucius and Bruening, Hoechst A. M., and sold under the trademarked name Novocaine, is now manufactured in the United States. Under the provisions of the Trading with the Enemy Act, the Federal Trade Commission has taken over the patent that gave monopoly for the manufacture and sale of the local anesthetic to the German corporation, and has issued licenses to American concerns for the manufacture of the product. This license makes it a condition that the product first introduced under the proprietary name "Novocaine" shall be called Procaine, and that it shall in every way be the same as the article formerly obtained from Germany. To insure this identity with the German Novocaine, the Federal Trade Commission has submitted the product of each firm licensed to the A. M. A. Chemical Laboratory to establish its chemical identity and purity, and to the Cornell pharmacologist, Dr. R. A. Hatcher, to determine that it was not unduly toxic.

So far, the following firms have been licensed to manufacture and sell Procaine:

The Abbott Laboratories, Ravenswood, Chicago.

Farbwerke-Hoechst Company, New York, N. Y.

Rector Chemical Co., Inc., New York, N. Y.

Calco Chemical Company, Bound Brook, N. J.

Yours truly,

JULIUS STIEGLITZ, *Chairman*  
*Subcommittee on Synthetic Drugs, National*  
*Research Council.*

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To physicians, interested in yeast as a therapeutic agent, it is important to note, in the report of this investigation, that the yeast used was not an unusual or special preparation, or one difficult to procure; but the familiar FLEISCHMANN'S COMPRESSED YEAST—the identical yeast used by bakers and housewives in making bread, and obtainable from virtually every grocer.

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A reprint is being issued for physicians, of this “Report on an Investigation into the Therapeutic Value of Compressed Yeast,” with added matter on the production of the yeast. If not received by you, a copy may be had upon request.

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